

Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

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DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

Chapter 182-18 GENERAL REQUIREMENTS FOR ALL ORGAN TRANSPLANT PROGRAMS

182-18-005	Purpose. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-005, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-010	Transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-010, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-020	New programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-020, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-030	Pediatric programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-030, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-040	Transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-040, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-050	Multiple organ transplants. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-050, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-060	Institutional commitment. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-060, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-070	Patient management. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-070, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-080	General recipient selection criteria for all organs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-080, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-090	Liver transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-090, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-100	Liver transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-100, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-110	Kidney transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-110, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-120	Kidney transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-120, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-130	Pancreas transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-130, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-140	Pancreas transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-140, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-150	Heart and/or heart-lung transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-150, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-18-160	Heart and/or heart-lung transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-160, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

Chapter 182-04 WAC PUBLIC RECORDS

WAC

182-04-010	Purpose.
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-04-030	Public records officer. [Order 01-77, § 182-04-030, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
182-04-065	Communication with the board. [Order 01-77, § 182-04-065, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state health care authority (HCA) with the provisions of chapter 42.17 RCW dealing with public records.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-010, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-010, filed 8/26/77.]

WAC 182-04-015 Definitions. The following definitions shall apply:

(1) "HCA" means the Washington state health care authority, created pursuant to chapter 41.05 RCW.

(2) "Public record" includes any writing containing information relating to the conduct of government or the performance of any governmental agency or the performance of any governmental or proprietary information.

(3) "Writing" means all means of recording any form of communication or representation as defined in RCW 42.17-020(28).

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-015, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-025 Public records. (1) All public records of the HCA as defined in WAC 182-04-015(2) shall be made available upon public request for inspection and copying pursuant to these rules, except however as provided by law.

(2) The public disclosure officer, or designee, shall respond promptly to requests for disclosure. Within five business days, the public disclosure officer, or designee shall respond by:

- (a) Providing the record;
- (b) Acknowledging the request and providing a reasonable estimate of the time it will take to respond to the request; or
- (c) Denying the public record request.

(3) In acknowledging receipt of a public record request that is unclear, the public disclosure officer may ask the requestor to clarify what information the requestor is seeking. If the requestor fails to clarify the request, the public disclosure officer need not respond to it.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-025, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-035 Office hours. Public records shall be made available upon request only during working hours of the HCA. For the purpose of this chapter, the working hours shall be from 9:00 a.m. until noon, and from 1:00 p.m. until 4:00 p.m., Monday through Friday, excluding legal holidays.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-035, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-035, filed 8/26/77.]

WAC 182-04-040 Request for public records. In accordance with the requirements of chapter 42.17 RCW that agencies prevent unreasonable invasion of privacy, and to protect public records from damage or disorganization, and to prevent excessive interference with essential functions of the agency, public records may be inspected or copied, or copies of such records may be obtained by the public, upon compliance with the following procedures:

(1) A request shall be made in writing or upon the form prescribed in WAC 182-04-070, which shall be available at the HCA. The form shall be presented to the public disclosure officer; or to any member of the agency's staff, if the public disclosure officer is not available, at the office of the agency during customary office hours. A request need merely identify with reasonable certainty the record sought to be disclosed. If the matter requested is referred to within the current index maintained by the public disclosure officer, a reference

to the requested record as it is described in such current index is desirable.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public disclosure officer or staff member to assist the member of the public in appropriately identifying the public record requested.

(3) When the law makes a record disclosable to a specific person, a requestor may be required to provide personal identification.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-040, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-040, filed 8/26/77.]

WAC 182-04-041 Preserving requested records. If a public record request is made at a time when such record exists but is scheduled for destruction in the near future, the public disclosure officer shall retain possession of the record, and may not destroy or erase the record until the request is resolved.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-041, filed 10/21/97, effective 11/21/97.]

WAC 182-04-045 Copying. (1) No fee shall be charged for the inspection of public records.

(2) The agency shall collect the following fees to reimburse the agency for its actual costs incident to providing copies of public records:

- (a) Fifteen cents per page for black and white photocopies, plus sales tax; and
- (b) The cost of postage, if any.

(3) The public disclosure officer is authorized to waive the foregoing costs. Factors considered in deciding whether to waive costs include, but are not limited to: Providing the copy will facilitate administering the program, and/or the expense of processing the payment exceeds the copying and postage cost.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-045, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 Exemptions. (1) The HCA reserves the right to determine whether a public record requested in accordance with the procedures outlined in WAC 182-04-040 is exempted under statutory provisions.

(2) Pursuant to RCW 42.17.260, the HCA reserves the right to delete identifying details when it makes available or publishes any public record, in any case where there is reason to believe that disclosure of such details would be an invasion of personal privacy or vital governmental interest protected by chapter 42.17 RCW. The public disclosure officer will fully justify such deletion in writing in such a way so that the nature of the deleted information is made known.

(3) If disclosure is denied, the requestor is entitled to a written explanation of the denial which cites the relevant exemption and an explanation of how it applies to the record being denied.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-050, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-050, filed 8/26/77.]

WAC 182-04-055 Review of denials of public records request. (1) Any person who objects to the denial of request for public record may petition for prompt review of such

decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public disclosure officer or other staff member which constituted or accompanied the denial.

(2) Following receipt of a written request for review of a decision denying a public record, the disclosure officer shall immediately consider the matter and either affirm or reverse such denial. Such review shall be deemed completed at the end of the second business day following the receipt by the disclosure officer of the request for review. This shall constitute final agency action for the purposes of judicial review, pursuant to RCW 42.17.320.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-055, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-055, filed 8/26/77.]

WAC 182-04-060 Protection of public records. Following are guidelines which shall be adhered to by any person inspecting such public records:

(1) Inspection of any public records shall be conducted only during working hours as specified in WAC 182-04-035 with the presence of an HCA employee;

(2) No public record shall be removed from the main office without the approval of the public disclosure officer or his/her designee;

(3) Public records shall not be marked, torn, or otherwise damaged;

(4) Public records must be maintained as they are in file or in a chronological order, and shall not be dismantled except for purposes of copying and then only by an HCA employee;

(5) Access to file cabinets and other places where public records are kept is restricted, and shall be used by employees of the HCA.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-060, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-070 Request for inspection of records. The HCA hereby adopts for use by all persons requesting inspection and/or copying of its records, the form set out below, entitled "Request for Inspection of Records."

The information requested in Blocks 4 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

1. Name	4. Phone Number
2. Address	5. Representing (if applicable)
3. Zip Code	6. If urgent - date needed

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(2007 Ed.)

(Signed)

Date

Return the request for inspection of records to:

Public Disclosure Office
Health Care Authority
676 Woodland Square Loop S.E.
Post Office Box 42705
Olympia, Washington 98504-2705

[Statutory Authority: RCW 41.05.160 and chapter 41.05 RCW, 98-17-063, § 182-04-070, filed 8/17/98, effective 9/17/98. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-070, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-070, filed 8/26/77.]

Chapter 182-08 WAC PROCEDURES

WAC

182-08-010	Declaration of purpose.
182-08-015	Definitions.
182-08-120	Employer contribution.
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182-08-190	The employer contribution shall be set by the HCA and paid to the HCA for all eligible employees.
182-08-196	What happens if my health carrier becomes unavailable?
182-08-197	Newly eligible employees must select insurance coverages within thirty-one days of the date they become eligible to apply for coverage.
182-08-198	When may an enrollee change health plans?
182-08-200	Which agency is responsible to pay the employer contribution for eligible employees changing agency employment?
182-08-220	Advertising or promotion of PEBB sponsored benefit plans.
182-08-230	Employer groups.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-08-020	Duties and responsibilities. [Statutory Authority: Chapter 41.05 RCW, 96-08-042, § 182-08-020, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-020, filed 12/8/76.] Repealed by 03-17-031 (Order 02-07), filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-08-030	Scope and construction of terms. [Order 7228, § 182-08-030, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-08-040	Definitions. [Order 7228, § 182-08-040, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-08-060	Approval of health maintenance organization plans. [Statutory Authority: RCW 41.05.010 and 41.05.025, 87-21-069 (Resolution No. 87-6), § 182-08-060, filed 10/19/87; Order 7228, § 182-08-060, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-08-080	Employee to elect option. [Order 7228, § 182-08-080, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
182-08-090	Transferred employee. [Order 3-77, § 182-08-090, filed 11/17/77; Order 7228, § 182-08-090, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
182-08-095	Waiver of coverage for active employees. [Statutory Authority: RCW 41.05.160 and 41.05.165, 03-17-031 (Order 02-07), § 182-08-095, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065, 01-24-048 (Order 01-05), § 182-08-095, filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160, 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; 97-21-126, § 182-

- 08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-110 Open enrollments. [Order 7228, § 182-08-110, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-111 Medical plan options between open enrollments. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by 91-20-163, filed 10/2/91, effective 11/2/91. Statutory Authority: Chapter 41.05 RCW.
- 182-08-125 PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-125, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-130 New dependents' medical coverage after enrollment. [Order 7228, § 182-08-130, filed 12/8/76.] Repealed by Order 3-77, filed 11/17/77.
- 182-08-140 New dependents' life coverage after enrollment. [Order 7228, § 182-08-140, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
- 182-08-150 Reduction or cancellation of optional insurance coverages. [Order 3-77, § 182-08-150, filed 11/17/77; Order 7228, § 182-08-150, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
- 182-08-160 Group coverage when not in pay status. [Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-165 Other group coverage option. [Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-170 Insurance status for a reverted employee. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-175 Group coverage while on family and medical leave. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-175, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-195 Retroactive employer and employee contributions restricted. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-210 Termination of employer paid insurance benefit programs. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-210, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-210, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-210, filed 11/17/77.] Repealed by 04-18-039, filed 8/26/04,

effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-300

Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

WAC 182-08-010 Declaration of purpose. The general purpose of this chapter is to establish a set of rules used by the Public Employees Benefits Board (PEBB) for designing employee and retiree eligibility and insurance benefits and for administration of these insurance plans by the Washington State Health Care Authority (HCA).

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-010, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-010, filed 12/8/76.]

WAC 182-08-015 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates other meaning:

"Administrator" means the administrator of the health care authority (HCA) or designee.

"Board" means the public employees' benefits board established under provisions of RCW 41.05.055.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB sponsored medical insurance by a retiree or surviving dependent.

"Dependent" means a person who meets eligibility requirements set forth in WAC 182-12-260.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Effective date of enrollment" means the first date on which an enrollee is entitled to receive covered benefits.

"Extended dependent" means a dependent child who is not the child of an enrollee through birth, adoption, marriage, or a qualified same sex domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild or a niece or nephew for whom the enrollee is the legal guardian or the enrollee has legal custody.

"Health carrier" has the meaning set forth at RCW 48.43.005(18) for purposes of administering this Title 182 WAC only, it includes the uniform medical plan and uniform dental plan.

"Health plan" or "plan" means medical and dental coverage.

"Insurance coverage" means any health plan, life or long-term disability insurance plan administered as a PEBB benefit.

"LTD insurance" includes basic long-term disability insurance paid for by the employer and long-term disability insurance offered to employees on an optional basis.

"Life insurance" includes basic life insurance paid for by the employer and life insurance offered to employees on an optional basis.

"Open enrollment" means a time period designated by the administrator during which enrollees may apply to trans-

fer their enrollment from one health carrier to another, enroll in medical coverage if the enrollee had previously waived such coverage, or add dependents.

"PEBB plan" or "PEBB benefits" means one or more insurance coverages approved by the public employees' benefits board for eligible enrollees and their dependents.

"Subscriber" or "insured" means the employee, retiree, COBRA beneficiary or surviving dependent who has been designated by the HCA as the individual to whom the HCA and the health carrier will issue all notices, information, requests and premium bills on behalf of enrolled dependents.

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB sponsored health plan by an employee (as defined in WAC 182-12-115) or a dependent who meets eligibility requirements set forth in WAC 182-12-260.

[Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-08-015, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-015, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-015, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

WAC 182-08-120 Employer contribution. The employers' contribution must be used to provide coverage for the basic life insurance benefit, a basic long term disability benefit, medical coverage, and dental coverage, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverages.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-120, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-120, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-08-120, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-120, filed 10/28/83; Order 3-77, § 182-08-120, filed 11/17/77; Order 7228, § 182-08-120, filed 12/8/76.]

WAC 182-08-180 Premium payments and refunds. PEBB premiums will be refunded using the following method:

(1) When a PEBB subscriber submits an enrollment change affecting eligibility, such as for example: Death, divorce, or when no longer a dependent as defined at WAC 182-12-260 no more than three months of accounting adjustments and any excess premium paid will be refunded to any individual or agency except as provided in WAC 182-12-148(3).

(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator or designee may approve a refund which does not exceed twelve months of premium provided both of the following occur:

(a) The PEBB subscriber or a dependent or beneficiary of a subscriber submits a written appeal to the HCA; and

(b) Proof is provided that extraordinary circumstances beyond the control of the subscriber, dependent or beneficiary made it virtually impossible to submit the necessary information to accomplish an enrollment change within sixty days after the event that created a change of premium.

(3) Errors resulting in an underpayment to HCA must be reimbursed by the employer or subscriber to the HCA. Upon request of an employer, subscriber, or beneficiary, as appropriate, the HCA will develop a repayment plan designed not to create undue hardship on the employer or subscriber.

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(4) HCA errors will be adjusted by returning the excess premium paid, if any, to the employer, subscriber, or beneficiary, as appropriate.

(5) Premium is due for the entire month of coverage and will not be prorated during the month of death or loss of eligibility of the enrollee except when eligible for life insurance conversion.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-180, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-180, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

WAC 182-08-190 The employer contribution shall be set by the HCA and paid to the HCA for all eligible employees. Every department, division, or agency of state government, and such county, municipal or other political subdivision, K-12 school district or educational service district that are covered under PEBB insurance coverage, shall pay premium contributions to the HCA for insurance coverage for all eligible employees and their dependents.

(1) Employer contributions shall be set by the HCA and are subject to the approval of the governor.

(2) Employer contributions shall include an amount determined by the HCA to pay administrative costs to administer insurance coverage for employees of these groups.

(3) Each eligible employee in pay status eight or more hours during a calendar month or each eligible employee on leave under the federal Family and Medical Leave Act (FMLA) shall be eligible for the employer contribution. The entire employer contribution is due and payable to HCA even if medical coverage is waived.

(4) PEBB insurance coverage for any county, municipality or other political subdivision or any K-12 school district or educational service district may be terminated by HCA if the premium contributions are delinquent more than ninety days.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

WAC 182-08-196 What happens if my health carrier becomes unavailable? Employees and retirees for whom the chosen health carrier becomes unavailable due to a change in service area, the health carrier no longer contracting, or the retiree's entitlement to Medicare must select a new health plan within sixty days after notification by the PEBB program.

(1) Employees that fail to select a new health plan within the prescribed time period will be enrolled in the health carrier's successor plan if one is available or will be enrolled in the Uniform Medical Plan and the Uniform Dental Plan with existing dependent enrollment by default.

(2) Retirees and surviving dependents eligible under WAC 182-12-250 or 182-12-265 that fail to select a new health plan within the prescribed time period will be enrolled in the health carrier's successor plan if one is available or will

be enrolled in the Uniform Medical Plan and the Uniform Dental Plan, except that retirees enrolled in Medicare Part A and B and who enroll in Medicare Part D may be defaulted to a PEBB-sponsored Medicare plan that does not include a pharmacy benefit.

Any employee or retiree defaulted to a carrier's successor plan, the Uniform Medical Plan or the Uniform Dental Plan may not change health plans until the next open enrollment except as set forth in WAC 182-08-198.

(3) Enrollees continuing PEBB health plan coverage as provided in WAC 182-12-133, 182-12-148 or 182-12-270 (2) or (3) must select a new health plan no later than sixty days after notification by the PEBB program or their health plan coverage will terminate as of the last day of the month in which the plan is no longer available.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-196, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

WAC 182-08-197 Newly eligible employees must select insurance coverages within thirty-one days of the date they become eligible to apply for coverage. Newly eligible employees must select a medical and dental plan (if dental is available based on employer participation in PEBB insurance coverages) no later than thirty-one days after they become eligible to apply for coverage. Employees who do not select a medical and dental plan will be defaulted to Uniform Medical Plan Preferred Provider Organization and Uniform Dental Plan.

[Statutory Authority: RCW 41.05.160. 06-11-156 (Order 06-02), § 182-08-197, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-197, filed 7/27/05, effective 8/27/05.]

WAC 182-08-198 When may an enrollee change health plans? (1) Enrollees may change health plans during the annual open enrollment. The enrollee must request the health plan change no later than the end of the open enrollment period. The new health plan's coverage will begin the first day of January after open enrollment.

(2) Enrollees may change health plans outside of the annual open enrollment period under some circumstances. To make a health plan change, the enrollee must send a completed enrollment form (and a completed disenrollment form, if required) to the PEBB program no later than sixty days after the event occurs. The new health plan's coverage will begin the first day of the month after the PEBB program receives the form(s). These are the circumstances:

(a) Enrollees may change health plans if they move and their current health plan is not available in their new location. If the enrollee does not select a new health plan, the PEBB program will automatically enroll them in the Uniform Medical Plan or Uniform Dental Plan.

(b) Enrollees may change health plans if they move and a health plan that was not available to them before is available to them in the new location. The enrollee may only choose a newly available health plan.

(c) Enrollees may change health plans if a court order requires the enrollee to provide coverage for an eligible

spouse, same-sex domestic partner, or child and the enrollee adds the dependent to their coverage.

(d) Seasonal employees whose off-season is during the annual open enrollment period may select a new health plan upon their return to work.

(e) Employees may change health plans when they enroll in PEBB retiree coverage.

(f) Enrollees may change health plans when they become entitled to Medicare or enroll in a Medicare Part D plan.

(g) Enrollees may not change their health plan if their physician stops participation with the enrollee's health plan unless the PEBB appeals manager determines that a continuity of care issue exists. The PEBB appeals manager will use criteria that include but are not limited to the following in determining if a continuity of care issue exists:

- (i) Active cancer treatment; or
- (ii) Recent transplant (within the last twelve months); or
- (iii) Scheduled surgery within the next sixty days; or
- (iv) Major surgery within the previous sixty days; or
- (v) Third trimester of pregnancy; or
- (vi) Language barrier.

(h) Enrollees may change health plans if they reach their medical plan's lifetime maximum.

[Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-08-198, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

WAC 182-08-200 Which agency is responsible to pay the employer contribution for eligible employees changing agency employment? When an eligible employee's employment ceases with an agency at any time prior to the end of the month for which a premium contribution is due and that employee transfers to another agency, the losing agency is responsible for the payment of the contribution for that employee for that month. The receiving agency would not be liable for any employer contribution for that eligible employee until the month following the transfer.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-200, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-200, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-200, filed 11/17/77.]

WAC 182-08-220 Advertising or promotion of PEBB sponsored benefit plans. (1) In order to assure equal and unbiased representation of PEBB plans, any promotion of these plans shall comply with all of the following:

(a) All materials describing PEBB plan benefits shall be prepared by or approved by the HCA prior to use.

(b) Distribution or mailing of all plan benefit descriptions shall be performed by or under the direction of the HCA.

(c) All media announcements or advertising by a carrier which include any mention of the "Public Employees Benefits Board," "health care authority" or any reference to coverage for "state employees or retirees" or any group of employees covered by PEBB plans, must receive the advance written approval of the HCA.

(2) Failure to comply with any or all of these requirements by a PEBB contracted carrier or subcontractor may

result in contract termination by the HCA, refusal to continue or renew a contract with the noncomplying party, or both.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-220, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-220, filed 3/29/96, effective 4/29/96; 91-20-163, § 182-08-220, filed 10/2/91, effective 11/2/91; 86-16-061 (Resolution No. 86-3), § 182-08-220, filed 8/5/86.]

WAC 182-08-230 Employer groups. This section applies to all employer groups, K-12 school districts and educational service districts participating in PEBB insurance coverages.

(1) For purposes of this section, "employer group" means those employee organizations representing state civil service employees, blind vendors, county, municipality, and political subdivisions that meet the participation requirements of WAC 182-12-111 (2), (3) and (4) and that participate in PEBB insurance coverages.

(2)(a) Each employer group shall determine an employee's eligibility for PEBB insurance coverage in accordance with the applicable sections of chapter 182-12 WAC, RCW 41.04.205, and chapter 41.05 RCW.

(b) Each employer group, K-12 school district and educational service district applying for participation in PEBB insurance coverage shall submit required documentation and meet all participation requirements set forth in the then-current *Introduction to PEBB Coverage K-12 and Employer Groups* booklet(s).

(3)(a) Each employer group, K-12 school district or educational service district applying for participation in PEBB insurance coverage shall sign an interlocal agreement with the HCA.

(b) Each interlocal agreement shall be renewed no less frequently than once in every two-year period.

(4) At least twenty days prior to the premium due date, the HCA shall cause each employer group, K-12 school district or educational service district to be sent a monthly billing statement. The statement of premium due will be based upon the enrollment information provided by the employer group, K-12 school district or educational service district.

(a) Changes in enrollment status shall be submitted to the HCA prior to the twentieth day of the month during which the change occurs. Changes submitted after the twentieth day of each month may not be reflected on the billing statement until the following month.

(b) Changes submitted more than one month late shall be accompanied by a full explanation of the circumstances of the late notification.

(5) An employer group, K-12 school district or educational service district shall remit the monthly premium as billed or as reconciled by it.

(a) If an employer group, K-12 school district or educational service district determines that the invoiced amount requires one or more changes, they may adjust the remittance only if an insurance eligibility adjustment form detailing the adjustment accompanies the remittance. The proper form for reporting adjustments will be attached to the interlocal agreement as Exhibit A.

(b) Each employer group, K-12 school district or educational service district is solely responsible for the accuracy of

the amount remitted and the completeness and accuracy of the insurance eligibility adjustment form.

(6) Each employer group, K-12 school district or educational service district shall remit the entire monthly premium due including the employee share, if any. The employer group, K-12 school district or educational service district is solely responsible for the collection of any employee share of the premium. The employer shall not withhold portions of the monthly premium due because it has failed to collect the entire employee share.

(7) Nonpayment of the full premium when due will subject the employer group, K-12 school district or educational service district to disenrollment and termination of each employee of the group.

(a) Prior to termination for nonpayment of premium, the HCA shall cause a notice of overdue premium to be sent to the employer group, K-12 school district or educational service district which notice will provide a one-month grace period for payment of all overdue premium.

(b) An employer group, K-12 school district or educational service district that does not remit the entirety of its overdue premium no later than the last day of the grace period will be disenrolled effective the last day of the last month for which premium has been paid in full.

(c) Upon disenrollment, notification will be sent to both the employer group, K-12 school district or educational service district and each affected employee.

(d) Employer groups, K-12 school districts or educational service districts disenrolled due to nonpayment of premium shall have the right to a dispute resolution hearing in accordance with the terms of the interlocal agreement.

(e) Employees terminated due to the nonpayment of premium by the employer group, K-12 school district or educational service district are not eligible for continuation of group health plan coverage according to the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Terminated employees shall have conversion rights to an individual insurance policy as provided for by the employer group, K-12 school district or educational service district.

(f) Claims incurred by terminated employees of a disenrolled group after the effective date of disenrollment will not be covered.

(g) The employer group, K-12 school district or educational service district is solely responsible for refunding any employee share paid by the employee to the employer group, K-12 school district or educational service district and not remitted to the HCA.

(8) A disenrolled employer group, K-12 school district or educational service district may apply for reinstatement in PEBB insurance coverages under the following conditions:

(a) Reinstatement must be requested and all delinquent premium paid in full no later than ninety days after the date the delinquent premium was first due, as well as a reinstatement fee of one thousand dollars.

(b) Reinstatement requested more than ninety days after the effective date of disenrollment will be denied.

(c) Employer groups, K-12 school districts or educational service districts may be reinstated only once in any two-year period and will be subject to immediate disenrollment if, after the effective date of any such reinstatement,

subsequent premiums become more than thirty days delinquent.

(9) Upon written petition by the employer group, K-12 school district or educational service district disenrollment of an employer group, K-12 school district or educational service district or denial of reinstatement may be waived by the administrator upon a showing of good cause.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-230, filed 8/26/04, effective 1/1/05.]

Chapter 182-12 WAC

ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

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182-12-205	Retirees may defer enrollment in PEBB health plan coverage at or after retirement.
182-12-211	If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB sponsored insurance coverage?
182-12-250	Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty.
182-12-260	Eligible dependents defined.
182-12-265	What options for continuing health plan coverage are available to widows, widowers and dependent children if the employee or retiree dies?
182-12-270	What options are available to dependents that cease to meet the definition of dependent in WAC 182-12-260?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-12-110	Purpose. [Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-110, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-110, filed 2/9/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-117	Eligible retirees. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-117, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 01-17-042 (Order 01-01), § 182-12-117, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-

117, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-117, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-12-118 Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty. [Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-047 (Order 01-04), § 182-12-118, filed 11/29/01, effective 12/30/01.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-12-119 Eligible dependents. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-119, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-119, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-119, filed 12/19/00, effective 1/19/01; 99-19-028 (Order 99-04), § 182-12-119, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-119, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-12-120 Noneligible employees. [Order 5646, § 182-12-120, filed 2/9/76.] Repealed by 88-12-034 (Resolution No. 88-1), filed 5/26/88, effective 7/1/88. Statutory Authority: RCW 41.05.010.

182-12-122 Surviving dependents eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-122, filed 8/5/86; 80-05-016 (Order 2-80), § 182-12-122, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-122, filed 7/26/78.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-124 Determination by department of retirement systems of retroactive eligibility for PEBB pension. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-124, filed 8/14/03, effective 9/14/03.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-12-125 Employee or dependents become ineligible for state group coverage. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-12-125, filed 4/16/84; Order 5646, § 182-12-125, filed 2/9/76.] Repealed by 84-14-058 (Order 5-84), filed 6/29/84. Statutory Authority: Chapter 41.05 RCW.

182-12-126 Extension of retiree dependents' eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-126, filed 8/5/86.] Repealed by 87-21-069 (Resolution No. 87-6), filed 10/19/87. Statutory Authority: RCW 41.05.010 and 41.05.025.

182-12-127 Extension of retiree dependents' eligibility. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-127, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-127, filed 9/19/88. Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-12-127, filed 10/19/87.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.

182-12-130 Retirees eligible for Medicare. [Statutory Authority: Chapter 41.05 RCW. 91-14-084, § 182-12-130, filed 7/1/91, effective 7/1/91; 80-05-016 (Order 2-80), § 182-12-130, filed 4/10/80; Order 4-77, § 182-12-130, filed 11/17/77; Order 5646, § 182-12-130, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-132 Deferring coverage at or following retirement. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-132, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-132, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-132, filed 12/19/00, effective 1/19/01; 97-21-127, § 182-12-132, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-132, filed 3/29/96, effective 4/29/96; 80-05-016 (Order 2-80), § 182-12-132, filed 4/10/80.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

- 182-12-135 Eligibility for employees on leave without pay. [Order 4-77, § 182-12-135, filed 11/17/77; Order 5646, § 182-12-135, filed 2/9/76.] Repealed by 80-05-016 (Order 2-80), filed 4/10/80. Statutory Authority: Chapter 41.05 RCW.
- 182-12-140 New eligible employees. [Order 4-77, § 182-12-140, filed 11/17/77; Order 5646, § 182-12-140, filed 2/9/76.] Repealed by 89-05-013 (Resolution No. 89-1), filed 2/9/89. Statutory Authority: RCW 41.05.065.
- 182-12-145 Insurance eligibility for higher education. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-145, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-145, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-145, filed 2/9/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-150 Husband and wife are eligible employees. [Order 5646, § 182-12-150, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
- 182-12-151 Dependent life insurance. [Order 01-77, § 182-12-151, filed 8/26/77.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-155 Classified employee eligible for employer contribution. [Order 5646, § 182-12-155, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
- 182-12-160 Elected officials. [Statutory Authority: Chapter 41.05 RCW. 86-06-003 (Resolution No. 86-1), § 182-12-160, filed 2/20/86; Order 5646, § 182-12-160, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-165 State contribution for permanent employees appointed to instructional year or seasonal positions. [Statutory Authority: RCW 41.05.010. 88-12-034 (Resolution No. 88-1), § 182-12-165, filed 5/26/88, effective 7/1/88; Order 7228, § 182-12-165, filed 12/8/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-170 State contributions for Medicare for actively employed. [Order 7228, § 182-12-170, filed 12/8/76.] Repealed by 83-22-042 (Resolution No. 6-83), filed 10/28/83. Statutory Authority: Chapter 41.05 RCW.
- 182-12-210 Extended self-pay medical and dental coverage. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-210, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-210, filed 9/19/88. Statutory Authority: Chapter 41.05 RCW. 87-07-034 (Resolution No. 87-2), § 182-12-210, filed 3/13/87; 86-16-061 (Resolution No. 86-3), § 182-12-210, filed 8/5/86.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.
- 182-12-215 Continued PEBB medical/dental coverage under COBRA. [Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-215, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.010 and 41.05.025. 91-11-010, § 182-12-215, filed 5/3/91, effective 6/3/91.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-220 Eligibility during appeal of dismissal. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-220, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-12-220, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-220, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-12-220, filed 8/5/86.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-230 Employer groups. [Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-230, filed 9/3/02, effective 10/4/02. Statutory Authority: RCW 41.05.160, 41.05.021 (1)(h). 02-08-047 (Order 01-09), § 182-12-230, filed 3/29/02, effective 4/29/02.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

enrollment in the public employees' benefits board (PEBB) approved benefits.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-108, filed 8/26/04, effective 1/1/05.]

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Administrator" means the administrator of the HCA or designee.

"Board" means the public employees' benefits board established under provisions of RCW 41.05.055.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB sponsored medical coverage by a retiree or surviving dependent.

"Dependent" means a person who meets eligibility requirements set forth in WAC 182-12-260.

"Effective date of enrollment" means the first date on which an enrollee is entitled to receive covered benefits.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Extended dependent" means a dependent child who is not the child of an enrollee through birth, adoption, marriage, or a qualified same sex domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild or a niece or nephew for whom the enrollee is the legal guardian or the enrollee has legal custody.

"Health carrier" has the meaning set forth at RCW 43.43.005(18) for purposes of administering this Title 182 WAC only, it includes the uniform medical plan and the uniform dental plan.

"Health plan" or "plan" means medical and dental coverages.

"Insurance coverage" means any health plan, life, or long-term disability insurance plan administered as a PEBB benefit.

"LTD insurance" includes basic long-term disability insurance paid for by the employer and long-term disability insurance offered to employees on an optional basis.

"Life insurance" includes basic life insurance paid for by the employer and life insurance offered to employees on an optional basis.

"Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their enrollment from one health carrier to another, enroll in medical coverage if the enrollee had previously waived such coverage or add dependents.

"PEBB plan" or "PEBB benefits" means one or more insurance coverages approved by the public employees' benefits board for eligible enrollees and their dependents.

"Subscriber" or "insured" means the employee, retiree, COBRA beneficiary or surviving dependent who has been designated by the HCA as the individual to whom the HCA and the health carrier will issue all notices, information, requests and premium bills on behalf of enrolled dependents.

WAC 182-12-108 Purpose. The purpose of this chapter is to establish eligibility criteria for and effective date of (2007 Ed.)

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB sponsored health plan by an employee (as set forth in WAC 182-12-115) or a dependent who meets eligibility requirements set forth in WAC 182-12-260.

[Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-109, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-109, filed 8/26/04, effective 1/1/05.]

WAC 182-12-111 Eligible entities and individuals.

The following entities and individuals shall be eligible to participate in PEBB insurance coverages subject to the terms and conditions set forth below:

(1) State agencies. Every department, division, or separate agency of state government, including all state higher education institutions, the higher education coordinating board, and the state board for community and technical colleges is required to participate in all PEBB approved insurance coverage. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(a) Employees of technical colleges previously enrolled in a benefits trust may terminate PEBB insurance coverage by January 1, 1996, or the expiration of the current collective bargaining agreements, whichever is later. Employees electing to terminate PEBB coverage have a one-time reenrollment option after a five year wait. Employees of a bargaining unit may terminate PEBB participation only as an entire bargaining unit. All administrative or managerial employees may terminate PEBB participation only as an entire unit.

(b) Community and technical colleges with employees enrolled in a benefits trust shall remit to the HCA a retiree remittance as specified in the omnibus appropriations act, for each full-time employee equivalent. The remittance may be prorated for employees receiving a prorated portion of benefits.

(2) Employee organizations. Employee organizations representing state civil service employees and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, may participate in PEBB sponsored insurance coverages at the option of each employee organization provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the group meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group, and the nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) The PEBB health plan must be the only employer sponsored health plan available to eligible employees.

(c) The legislative authority or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application to participate in PEBB insurance coverage is subject to the approval of the HCA.

(d) The legislative authority or the board of directors must maintain its PEBB plan participation for a minimum of

one full year, and may terminate participation only at the end of a plan year.

(e) The terms and conditions for the payment of the insurance premiums shall be set forth in the provisions of the bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.

(f) The eligibility requirements for dependents must be the same as the requirements for dependents of the state employees and retirees as set forth in WAC 182-12-260.

(g) The legislative authority or the board of directors shall provide the HCA with written notice of its intent to terminate PEBB plan participation no fewer than thirty days prior to the effective date of termination. If the employee organization terminates coverage in PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible to participate in PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(3) Blind vendors means a "licensee" as defined in RCW 74.18.200: Vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind may voluntarily participate in PEBB insurance coverage.

(a) Vendors that do not enroll when first eligible may enroll only during the annual open enrollment period offered by the HCA or the first day of the month following loss of other insurance coverage.

(b) Department of services for the blind will notify eligible vendors of their eligibility in advance of the date that they are eligible to apply for enrollment in PEBB insurance coverage.

(c) The eligibility requirements for dependents of blind vendors shall be the same as the requirements for dependents of the state employees and retirees as set forth in WAC 182-12-260.

(4) Local governments: Employees of a county, municipality, or other political subdivision of the state may participate in PEBB insurance coverage provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the group meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group, and the nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) The PEBB health plan must be the only employer sponsored health plan available to eligible employees.

(c) The legislative authority or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application to participate in PEBB insurance coverage is subject to the approval of the HCA.

(d) The legislative authority or the board of directors must maintain its PEBB plan participation for a minimum of

one full year, and may terminate participation only at the end of the plan year.

(e) The terms and conditions for the payment of the insurance premiums must be set forth in the provisions of the bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.

(f) The eligibility requirements for dependents of local government employees must be the same as the requirements for dependents of state employees and retirees as set forth in WAC 182-12-260.

(g) The legislative authority or the board of directors shall provide the HCA with written notice of its intent to terminate PEBB plan participation no fewer than thirty days prior to the effective date of termination. If a county, municipality, or political subdivision terminates coverage in PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible to participate in PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(5) K-12 school districts and educational service districts: Employees of school districts or educational service districts may participate in PEBB insurance programs provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the K-12 school district or educational service district meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group. For the purpose of enrolling by bargaining unit, all nonrepresented employees will be considered a single bargaining unit.

(b) The school district or educational service district must submit an application together with employee census data and, if available, prior claims experience of the entity to the HCA. The application to participate in the PEBB insurance coverage is subject to the approval of the HCA.

(c) The school district or educational service district must agree to participate in all PEBB insurance coverage. The PEBB health plan must be the only employer sponsored health plan available to eligible employees.

(d) The school district or educational service district must maintain its PEBB plan participation for a minimum of one full year, and may terminate participation only at the end of the plan year.

(e) Beginning September 1, 2003, the HCA will collect an amount equal to the composite rate charged to state agencies plus an amount equal to the employee premium by health carrier and family size as would be charged to state employees for each participating school district or educational service district. Each participating school district or educational service district must agree to collect an employee premium by health carrier and family size that is not less than that paid by state employees. The eligibility requirements for employees will be the same as those for state employees as defined in WAC 182-12-115.

(f) The eligibility requirements for dependents of K-12 school district and educational service district employees

must be the same as the requirements for dependents of the state employees and retirees as set forth in WAC 182-12-260.

(g) The school district or educational district must provide the HCA with written notice of its intent to terminate PEBB plan participation no fewer than thirty days prior to the effective date of termination, and may terminate participation only at the end of a plan year.

(6) Eligible nonemployees:

(a) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB health plan coverage while enrolled in that program.

(b) School board members or students eligible to participate under RCW 28A.400.350 may participate in PEBB insurance coverage as long as they remain eligible under that section.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-111, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-12-111, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-111, filed 9/3/02, effective 10/4/02; 99-19-028 (Order 99-04), § 182-12-111, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-111, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-111, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.04.205, 41.05.065, 41.05.011, 41.05.080 and chapter 41.05 RCW. 92-03-040, § 182-12-111, filed 1/10/92, effective 1/10/92. Statutory Authority: Chapter 41.05 RCW. 78-02-015 (Order 2-78), § 182-12-111, filed 1/10/78.]

WAC 182-12-112 Insurance eligibility for higher education. For the purpose of insurance eligibility, the HCA considers the higher education personnel board, the council for postsecondary education, and the state board for community colleges to be higher education agencies.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-112, filed 8/26/04, effective 1/1/05.]

WAC 182-12-115 Eligible employees. The following employees of state government, higher education, participating K-12 school districts, educational service districts, political subdivisions and employee organizations representing state civil service workers are eligible for PEBB insurance coverage.

A person whose employment situation can be described by more than one of the eligibility categories in subsections (1) through (7) of this section shall have his or her eligibility determined solely by the criteria of the one category that most closely describes his or her employment situation.

(1) "Permanent employees." Those who work at least half-time per month and are expected to be employed for more than six months. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.

(2) "Nonpermanent employees." Those who work at least half-time and are expected to be employed for no more than six months. Coverage begins on the first day of the seventh month following the date of employment.

(3) "Career seasonal employees." Those who work at least half-time per month during a designated season for a minimum of three months but less than twelve months per year and who have an understanding of continued employment season after season. Coverage begins on the first day of

the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment. Career seasonal employees who work at least half-time per month for a season that extends for nine or more months are eligible for the employer contribution during the break between seasons of employment. However, career seasonal employees who work at least half-time per month for less than nine months in a season are not eligible for the employer contribution during the break between seasons of employment but may be eligible to continue coverage by self-paying premiums.

(4) "Instructional year employees." Employees who work half-time or more on an instructional year (school year) or equivalent nine-month basis. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of the month, coverage begins on the date of employment. These employees are eligible to receive the employer contribution for insurance during the off-season following each instructional year period of employment. The provisions of this subsection do not apply to persons employed on a quarter-to-quarter or semester-to-semester contract basis.

(5)(a) "Part-time faculty" and "part-time academic employees." Employees who are employed on a quarter/semester to quarter/semester basis are eligible for coverage beginning with the second consecutive quarter/semester of half-time or more employment at one or more state institutions of higher education including one or more college districts. Coverage begins on the first day of the month following the beginning of the second quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

For the purpose of determining eligibility for part-time faculty and part-time academic employees, employers must:

(i) Consider spring and fall as consecutive quarters/semesters when first establishing eligibility; and

(ii) Determine "half-time or more employment" based on each institution's definition of "full-time"; and

(iii) At the beginning of each quarter/semester notify, in writing, all current and newly hired part-time faculty and part-time academic employees of their potential right to benefits under this subsection; and

(iv) Where concurrent employment at more than one state higher education institution is used to determine total employment of half-time or more, the employing institutions will arrange to prorate the cost of the employer insurance contribution based on the employment at each institution. However, if the employee would be eligible by virtue of employment at one institution, that institution will pay the entire cost of the employer contribution regardless of other higher education employment. In cases where the cost of the contribution is prorated between institutions, one institution will forward the entire contribution monthly to HCA.

Part-time faculty and part-time academic employees employed at more than one state institution of higher education are responsible for notifying each employer quarterly, in writing, of the employee's multiple employment. In no case will retroactive coverage be permitted or employer contribution paid to HCA if an employee fails to inform all of his/her

employing institutions about employment at all institutions within the current quarter.

Once enrolled, if a part-time faculty or part-time academic employee does not work at least a total of half-time in one or more state institutions of higher education, eligibility for the employer contribution ceases.

(b) Part-time academic employees of community and technical colleges who have a reasonable expectation of continued employment at one or more college districts shall be eligible for the employer contribution for benefits during the period between the end of the spring quarter and the beginning of the fall quarter, or other quarter break period, if they meet the following conditions of this subsection (5)(b).

Part-time academic employees who work half-time or more in each instructional year quarter of an academic year, or equivalent nine-month season, in a single college district or multiple college districts, as determined from the payroll records of the employing community or technical college district(s), are eligible for the employer contribution for health benefits during the quarter or off season period immediately following the end of one academic year or equivalent nine-month season.

For the purposes of this subsection (5)(b):

(i) "Academic employee" has the meaning set forth in RCW 28B.50.489(3).

(ii) "Academic year" means fall, winter, and spring quarters in a community or technical college, as determined from the payroll records of the employing college district or college districts.

(iii) "Equivalent nine-month seasonal basis" means a nine consecutive month period of employment at half-time or more by a single college district or multiple college districts, as determined from the payroll records of the employing college district(s).

(iv) "Health benefits" means the particular medical and/or dental coverage in place at the end of the academic year or equivalent nine-month season. Changes to health benefits may be made only as set forth in chapter 182-08 WAC or during an annual open enrollment period.

(c) Part-time academic employees who have established eligibility, as determined from the payroll records of the employing community or technical college districts, for employer contributions for benefits and who have worked an average of half-time or more in each of the two preceding academic years, through employment at one or more community or technical college districts, are eligible for continuation of employer contributions for the subsequent summer period between the end of the spring quarter and the beginning of the fall quarter.

(d) Once a part-time academic employee meets the criteria in (c) of this subsection, the employee shall continue to receive uninterrupted employer contributions for benefits if the employee works at least three of the four quarters of the academic year with an average academic year workload of half-time or more. Benefits provided under this subsection (5)(d) cease at the end of the academic year if this criteria is not met. Continuous benefits shall be reinstated once the employee reestablishes eligibility under (c) of this subsection.

(e) As used in (c) and (d) of this subsection, "academic year" means the summer, fall, winter, and spring quarters. As

used in this subsection, "academic employees" has the meaning provided in RCW 28B.50.489.

(f) To be eligible for maintenance of benefits through averaging pursuant to (c) and (d) of this subsection, part-time academic employees must notify their employers of their potential eligibility.

(6) "Appointed and elected officials." Legislators are eligible to apply for coverage on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or they take the oath of office, whichever occurs first. Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of the month, coverage begins on the first day of their term. Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of the month, coverage begins on the date the term begins, or the oath of office is taken.

(7) "Judges." Justices of the supreme court and judges of courts of appeals and the superior courts become eligible to apply for coverage on the date they take the oath of office. Coverage begins on the first day of the month following the date their term begins, or the first day of the month following the date they take oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

[Statutory Authority: RCW 41.05.160, 06-12-002 (Order 06-01), § 182-12-115, filed 5/25/06, effective 6/25/06; 05-17-132 (Order 04-04), § 182-12-115, filed 8/19/05, effective 9/2/05. Statutory Authority: RCW 41.05.160 and 41.05.165, 03-17-031 (Order 02-07), § 182-12-115, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW, 96-08-043, § 182-12-115, filed 3/29/96, effective 4/29/96; 92-08-003, § 182-12-115, filed 3/18/92, effective 3/18/92; 91-14-084, § 182-12-115, filed 7/1/91, effective 7/1/91. Statutory Authority: RCW 41.05.065(3), 90-12-037, § 182-12-115, filed 5/31/90, effective 7/1/90. Statutory Authority: RCW 41.05.065, 89-12-045 (Resolution No. 89-2), § 182-12-115, filed 6/2/89; 89-01-053 (Resolution No. 88-6), § 182-12-115, filed 12/15/88. Statutory Authority: RCW 41.05.010, 88-19-078 (Resolution No. 88-4), § 182-12-115, filed 9/19/88; 88-12-034 (Resolution No. 88-1), § 182-12-115, filed 5/26/88, effective 7/1/88. Statutory Authority: Chapter 41.05 RCW, 86-21-042 (Resolution No. 86-6), § 182-12-115, filed 10/10/86; 83-12-007 (Order 2-83), § 182-12-115, filed 5/20/83; 80-05-016 (Order 2-80), § 182-12-115, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-115, filed 7/26/78; Order 5646, § 182-12-115, filed 2/9/76.]

WAC 182-12-116 Who is eligible to participate in the PEBB flexible spending account plan? Beginning January 1, 2006, all employees of public four-year institutions of higher education, of the state community and technical colleges and of the state board for community and technical colleges who are eligible for PEBB insurance benefits, as defined in WAC 182-12-115, are eligible to participate in the PEBB medical flexible spending account plan. Beginning July 1, 2006, all employees of state agencies who are eligible for PEBB insurance benefits, are eligible to participate in the PEBB medical flexible spending account plan.

If an employee terminates employment after becoming a plan participant and later on in the same plan year is hired

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into a new position that is eligible for PEBB insurance benefits, the employee may not resume participation in the PEBB medical flexible spending account until the beginning of the next plan year.

[Statutory Authority: RCW 41.05.160, 06-11-156 (Order 06-02), § 182-12-116, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-12-116, filed 7/27/05, effective 8/27/05.]

WAC 182-12-121 Does a change in position or job affect eligibility status? Employees who voluntarily move from an eligible to an otherwise noneligible position shall retain their eligibility for the employer contribution each month in which they are in pay status eight or more hours, provided, (1) the new position is one in which the employee is scheduled to work half time or more, and (2) the employee did not terminate state service before taking the new position. Layoff because of reduction in force is not considered termination of state service. Proviso (1) above does not apply to employees who are on reduction in force status.

[Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-121, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW, 80-01-082 (Order 5-79), § 182-12-121, filed 12/27/79.]

WAC 182-12-123 Dual eligibility is prohibited. Health plan coverage is limited to a single enrollment per individual.

(1) Effective January 1, 2002, individuals that have more than one source of eligibility for enrollment in PEBB health coverage (called "dual eligibility") are limited to one enrollment.

(2) One insurance-eligible employee may waive medical coverage for himself or herself and enroll as a spouse or dependent on the coverage of his or her eligible spouse. This waiver option is not available for other insurance coverages.

(3) The following examples describe typical situations of dual eligibility. These are not the only situations where dual eligibility may arise. These examples are provided as illustrations only.

(a) A husband and wife who are both insurance-eligible and employed by PEBB-participating employers, such as state agencies, may enroll only in a health plan as an employee but not also as a dependent. That is, the husband may enroll only under his employing agency and the wife may enroll only under her employing agency but not also as dependents of each other. In the alternative, one spouse may waive medical coverage as an employee and enroll as a dependent on the medical coverage of the other spouse.

(b) A dependent child that is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the health plan coverage of one parent or stepparent, but not more than one.

(c) An employee employed in an insurance-eligible position by more than one PEBB-participating employer may enroll only under one employer. The employee may choose to enroll in a health plan under the employer that:

- (i) Offers the most favorable cost-sharing arrangement; or
- (ii) Employed the employee for the longer period of time.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-123, filed 8/26/04, effective 1/1/05.]

WAC 182-12-128 May an employee waive enrollment in PEBB insurance coverage? (1) Employees eligible for PEBB insurance coverage have the option of waiving health plan coverage if they are covered by other health plan coverage. If an employee waives health plan coverage, such coverage is automatically waived for all eligible dependents. An employee may choose to enroll only himself or herself, and waive either the medical or dental portion of the health plan coverage, or both, for any or all dependents. In order to waive enrollment, the employee must complete an enrollment form and list all enrollees for whom coverage is being waived.

(2) An employee may only waive the medical portion of health plan coverage. The employee must remain enrolled in the dental, life and LTD insurance coverages.

(3) If the medical portion of the health plan coverage is waived, an otherwise eligible enrollee may not rescind the waiver and reenroll in the medical portion of the health plan coverage except during the following times:

(a) The next open enrollment period; or

(b) Within sixty days of loss of other medical coverage if proof of enrollment in other comprehensive group medical coverage is submitted and demonstrates that:

(i) Enrollment in other medical coverage was continuous from the most recent open enrollment period for which PEBB medical coverage was waived; and

(ii) The period between loss of the other medical coverage and application for PEBB medical coverage is sixty days or less.

(4) If the dental portion of the health plan coverage is waived, an otherwise eligible dependent may not enroll in PEBB dental coverage except during the following times:

(a) The next open enrollment period; or

(b) Within sixty days after loss of other dental coverage if proof of enrollment in other dental coverage is submitted and demonstrates that:

(i) Enrollment in the other dental coverage was continuous from the most recent open enrollment period for which dental was waived; and

(ii) The period between loss of the other dental and application for PEBB dental coverage is sixty days or less.

(5) The employee and eligible dependents may have an additional opportunity to reenroll only as a result of addition of a new dependent due to marriage, birth, adoption, or placement for adoption, provided that advice of such enrollment is provided to HCA within thirty-one days after the marriage or within sixty days after the birth, adoption or placement for adoption of a child.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-128, filed 8/26/04, effective 1/1/05.]

WAC 182-12-131 When does employer paid insurance coverage end? PEBB medical, dental and life insurance coverages for a terminated employee, spouse, qualified same sex domestic partner or dependent child ceases at 12:00 midnight, the last day of the month in which the employee or dependent is eligible. Basic long term disability coverage

ceases at 12:00 midnight the date employment terminates or immediately upon the death of the employee.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-131, filed 8/26/04, effective 1/1/05.]

WAC 182-12-133 What options for continuing coverage are available to employees when they are no longer eligible for PEBB insurance coverage paid for by their employer? Eligible employees covered by PEBB insurance coverage have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility. Except in the case of approved family and medical leave, and except as otherwise provided, only employees in pay status eight or more hours per month are eligible to receive the employer contribution.

(1) When an employee is on leave without pay due to an event described in (a) through (f) of this subsection, insurance coverage may be continued at the group rate by self-paying premiums. Employees may self-pay for a maximum of twenty-nine months. The number of months that an employee self-pays premium during a period of leave without pay will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave may continue long term disability insurance. The following types of leave qualify to continue coverage under this provision:

(a) The employee is on authorized leave without pay;

(b) The employee is laid off because of a reduction in force (RIF);

(c) The employee is receiving time-loss benefits under workers' compensation;

(d) The employee is applying for disability retirement;

(e) The employee is called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); however, self-payment of life insurance is limited to twelve months from the date the employee is called to active duty;

(f) The employee is on approved educational leave.

(2) Part-time faculty may self-pay premium at the group rate between periods of eligibility for a maximum of eighteen months. Part-time faculty may continue any combination of medical, dental and life insurance.

(3) The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives enrollees the right to continue group medical and dental coverage for a period of eighteen to thirty-six months when they lose eligibility due to one of the following qualifying events.

(a) Termination of employment.

(b) The employee's hours are reduced to the extent of losing eligibility.

(4) Employees who are approved for leave under the federal Family and Medical Leave Act (FMLA) are eligible to receive the employer contribution toward premium for up to twelve weeks, as provided in WAC 182-12-138.

[Statutory Authority: RCW 41.05.160. 06-11-156 (Order 06-02), § 182-12-133, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-133, filed 8/26/04, effective 1/1/05.]

WAC 182-12-136 May an employee on approved educational leave waive PEBB health plan coverage? In order to avoid duplication of group health plan coverage, the following shall apply to employees during any period of approved educational leave. Employees eligible for coverage provided in WAC 182-12-133 who obtain comprehensive health plan coverage under another group plan may waive continuance of such coverage for each full calendar month in which they maintain coverage under the other comprehensive group health plan. These employees have the right to reenroll in PEBB health plan coverage effective the first day of the month after the date the other comprehensive group health plan coverage terminates, provided proof of such other comprehensive group health plan coverage is provided to the HCA upon application for reenrollment.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-136, filed 8/26/04, effective 1/1/05.]

WAC 182-12-138 If an employee is approved for family and medical leave, what PEBB insurance coverage may be continued? Employees on leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to twelve weeks of employer-paid group medical, dental, basic life, and basic long-term disability insurance while on family and medical leave and may also continue current optional life and long-term disability. All employee premium amounts associated with insurance coverage must be paid monthly as they become due. If premiums are more than sixty days delinquent, insurance coverage will be terminated as of the last day of the month of fully paid coverage.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-138, filed 8/26/04, effective 1/1/05.]

WAC 182-12-141 If I revert from an eligible position to an ineligible position what happens to my insurance coverage? Employees who revert to a position that is ineligible for employer contribution toward insurance coverage may continue health plan coverage by self-paying premium for up to eighteen months (and in some cases up to twenty-nine months) under the same terms as an employee who is granted leave without pay.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-141, filed 8/26/04, effective 1/1/05.]

WAC 182-12-146 PEBB health plan coverage under COBRA. Enrollees and eligible dependents who become ineligible for health plan coverage and who qualify for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue their plan coverage by self-payment of plan premiums in accordance with COBRA statutes and regulations.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-146, filed 8/26/04, effective 1/1/05.]

WAC 182-12-148 May an employee continue PEBB insurance coverage during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their insurance coverage by self-payment of premium on the same terms as an employee who is granted leave without pay.

(a) For an appeal filed on or before June 30, 2005, the personnel appeals board or any court.

(b) For an appeal filed on or after July 1, 2005, the personnel resources board, an arbitrator, a grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) If the dismissal is upheld, all insurance coverage shall terminate at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is earlier.

(3)(a) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid insurance coverage retroactively, the employer must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(b) HCA will refund to the employee any premiums the employee paid that may be provided for as a result of the reinstatement of the employer contribution only if the employee makes retroactive payment of any employee contribution amounts associated with the insurance coverage. In the alternative, at the request of the employee, HCA may deduct the employee's contribution from the refund of any premiums self-paid by the employee during the appeal period.

(c) All optional life and long term disability insurance which was in force at the time of dismissal shall be reinstated retroactively only if the employee makes retroactive payment of premium for any such optional coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to restore such optional coverage.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-148, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-148, filed 8/26/04, effective 1/1/05.]

WAC 182-12-171 Eligible retirees. (1) Eligible employees who terminate public employment after becoming vested in a Washington state sponsored retirement system are eligible to continue PEBB sponsored insurance coverage as a retiree provided the following requirements in (a) and (b) of this subsection as well as one of (c) through (g) of this subsection are met:

(a) If the retiree or enrolled dependent(s) is entitled to Medicare and the retiree retired after July 1, 1991, the Medicare-entitled retiree or Medicare-entitled dependent must enroll in both Medicare Parts A and B; and

(b) The retiring employee must submit an election form to enroll or defer health plan coverage within sixty days after their employer paid or continuous Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends and is eligible for retiree benefits under one or more of the programs described in (c), (d), (e), (f), or (g) of this subsection;

(c) Except as provided in (c)(vii) of this subsection, the person immediately upon termination begins receiving a monthly retirement income benefit from one or more of the following retirement systems:

(i) Law enforcement officers' and fire fighters' retirement system Plan 1 or 2;

- (ii) Public employees' retirement system Plan 1 or 2;
- (iii) Public safety employees' retirement system;
- (iv) School employees' retirement system Plan 2;
- (v) State judges/judicial retirement system;
- (vi) Teachers' retirement system Plan 1 or 2; or
- (vii) Washington state patrol retirement system.

(viii) Provided, however, that a lump-sum payment may be received in lieu of a monthly retiree income benefit payment under RCW 41.26.425(1), 41.32.762(1), 41.32.870(1), 41.35.410(1), 41.35.670(1), 41.37.200(1), 41.40.625(1) or 41.40.815(1).

(d) The person is at least fifty-five years of age with at least ten years of state of Washington service credit and a member of one of the following retirement systems:

- (i) Public employees' retirement system Plan 3;
- (ii) School employees' retirement system Plan 3; or
- (iii) Teachers' retirement system Plan 3.

(e) The person is a member of a state of Washington higher education retirement plan, and is:

- (i) At least fifty-five years of age with at least ten years service; or
- (ii) At least sixty-two years of age; or
- (iii) Immediately begins receiving a monthly retirement income benefit.

(f) If not retiring under the public employees' retirement system, the person would have been eligible for a monthly retirement income benefit because of age and years of service had the person been employed under the provisions of public employees' retirement system Plan 1 or Plan 2 for the same period of employment.

(g) The person is an elected official as defined under WAC 182-12-115(6) who has voluntarily or involuntarily left a public office, whether or not the person receives a benefit from a state retirement system.

(2) Eligible employees who participate in PEBB sponsored life insurance as an active employee and meet qualifications for retiree insurance coverage as provided in subsection (1) of this section are eligible for PEBB sponsored retiree life insurance if they submit an election form no later than sixty days after the date their PEBB employee life insurance terminates, providing their employee life insurance premium is not being waived by the life insurance carrier at the time they elect retiree life insurance.

(3) The following retired and disabled school district and educational service district employees are eligible to participate in health plan coverage only, provided they meet all of the enrollment criteria stated below and, if they are entitled to Medicare, are also enrolled in both Medicare Parts A and B:

(a) Persons receiving a retirement allowance under chapter 41.32, 41.35 or 41.40 RCW as of September 30, 1993, and who enroll in PEBB health plan coverage not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995;

(b) Persons who separate from employment with a school district or educational service district due to a total and permanent disability and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35 or 41.40 RCW. Such persons must enroll in PEBB health plan coverage not later than the end of the open enrollment period established by the HCA for the plan year beginning January 1, 1995, or sixty days following retirement, whichever is later.

(4) With the exception of the Washington state patrol, retirees and disabled employees are not eligible for an employer premium contribution.

(5) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement System, shall be considered a Washington state sponsored retirement system for Washington State University Extension employees who are covered under the PEBB insurance coverage at the time of retirement or disability.

(6) Employees who do not elect enrollment in PEBB retiree insurance coverage no later than sixty days immediately after termination of employment for retirement, or immediately after continuous Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends, or who terminate PEBB retiree coverage no later than sixty days after retirement, or who terminate PEBB retiree coverage after retirement, are not eligible to reenroll in PEBB retiree insurance coverage unless they retired and deferred PEBB retiree coverage pursuant to WAC 182-12-205 or retired and deferred PEBB retiree coverage pursuant to WAC 182-12-200.

(7)(a) If a retiree's insurance coverage terminates for any reason, coverage will not be reinstated at a later date. Examples of termination include, but are not limited to, any one or more of the following:

- (i) Failure to continue to meet eligibility requirements;
- (ii) Fraud, intentional misrepresentation or withholding of information the enrollee knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
- (iii) Failure to provide information requested by the due date or knowingly providing false information;
- (iv) Abusive or offensive conduct repeatedly directed to an HCA employee, a health plan or other HCA contractor providing coverage on behalf of the PEBB program, its employees, or other persons; or
- (v) Intentional misconduct.

(b) If a retiree fails to pay the premium when due or an underpayment of premium is made, PEBB sponsored insurance coverage will terminate on the last day of the month for which the last full premium was received.

(c) Notwithstanding (a) of this subsection, the PEBB assistant administrator or designee may approve reinstatement of insurance coverage if the retiree or their dependent or beneficiary submits a written appeal and provides proof that extraordinary circumstances made it virtually impossible to make the payment and the retiree agrees to make payment in accordance with the terms of an agreement with the HCA. No insurance coverage will be reinstated more than three times.

(8) Enrollees may not enroll in retiree dental coverage unless they also enroll in retiree medical coverage.

(9) In order to continue retiree term life insurance, an election must be made within sixty days after retirement and premiums must be paid whether or not the retiree is otherwise employed. Election of retiree term life insurance may not be waived or deferred during periods of other coverage or otherwise.

[Statutory Authority: RCW 41.05.160, 06-11-156 (Order 06-02), § 182-12-171, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-12-171, filed

7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-171, filed 8/26/04, effective 1/1/05.]

WAC 182-12-175 May a local government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit? Local government entities applying for participation in PEBB insurance coverage under WAC 182-12-111(4), may request inclusion of retired employees who are covered under their retiree health plan at the time of application. The PEBB program will use the following criteria for approval of these requests for inclusion of retirees.

(1) The local government retiree health plan must have existed for a minimum of three years prior to the date of application for participation in PEBB health plans.

(2) Eligibility for coverage under the local government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage.

(3) The retiree must have maintained continuous enrollment in their local government retiree health plan.

(4) To protect the integrity of the risk pool, if total local government retiree enrollment exceeds ten percent of the total PEBB retiree population, the PEBB program may:

(a) Stop approving inclusion of retirees with local government unit transfers; or

(b) May adopt a new rating methodology reflective of the cost of covering local government retirees.

(5) Retirees and dependents included in the transfer unit are subject to the enrollment and eligibility rules outlined in chapters 182-08, 182-12 and 182-16 WAC.

(6) Employees eligible for retirement subsequent to the local government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-175, filed 7/27/05, effective 8/27/05.]

WAC 182-12-190 May a retiree change health carriers at retirement? Retirees eligible to continue their insurance coverage after retirement may elect to change health carriers at the time of retirement.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-190, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 80-05-016 (Order 2-80), § 182-12-190, filed 4/10/80; Order 4-77, § 182-12-190, filed 11/17/77.]

WAC 182-12-200 May a retiree who is enrolled in PEBB sponsored or Washington state K-12 school district sponsored health plan coverage defer enrollment in PEBB retiree health plans? A retiree, whose spouse is enrolled as an eligible employee in a PEBB or Washington state school district sponsored health plan, may defer enrollment in PEBB retiree health plan coverage and enroll in the spouse's PEBB or school district sponsored health plan coverage. If a retiree defers enrollment in PEBB retiree medical coverage, enrollment must also be deferred for dental coverage. The retiree and eligible dependents may subsequently enroll in PEBB retiree medical coverage, or medical and dental coverage if the retiree was continuously enrolled under the spouse's PEBB or school district sponsored health plan cov-

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erage from the date the retiree was initially eligible for retiree insurance coverage:

(1) During any open enrollment period determined by the HCA; or

(2) Within sixty days after the date the spouse ceases to be enrolled in a PEBB or school district sponsored health plan as an eligible employee; or

(3) Within sixty days of the date after the retiree's loss of eligibility as a dependent under the spouse's PEBB or school district sponsored health plan coverage.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-200, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160. 01-17-041 (Order 01-00), § 182-12-200, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-200, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-200, filed 3/29/96, effective 4/29/96; Order 4-77, § 182-12-200, filed 11/17/77.]

WAC 182-12-205 Retirees may defer enrollment in PEBB health plan coverage at or after retirement. Except as stated in subsection (1)(c) of this section, if a retiree defers enrollment in PEBB health plan coverage, PEBB also waives coverage for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other coverage.

(1) Retirees may defer enrollment in PEBB health plan coverage at or after retirement if continuously enrolled in other medical coverage as stated below:

(a) Beginning January 1, 2001, retirees may defer their PEBB health plan coverage if enrolled in comprehensive employer-sponsored medical coverage as an employee or the spouse or same-sex domestic partner of an employee.

(b) Beginning January 1, 2001, retirees may defer their PEBB health plan coverage if enrolled in medical coverage as a retiree or the spouse or same-sex domestic partner of a retiree enrolled in a federal retiree plan.

(c) Beginning January 1, 2006, retirees may defer their PEBB health plan coverage if enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage as defined in this chapter. The retiree's dependents may continue their PEBB coverage if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a Medicaid program.

(2) To defer health plan coverage, the retiree must send a completed enrollment form to the PEBB program requesting to defer coverage. The PEBB program must receive the form before coverage is deferred or no later than sixty days after the date the retiree becomes eligible to apply for PEBB retiree benefits.

(3) Retirees who defer PEBB coverage may enroll in PEBB coverage as follows:

(a) Retirees who defer PEBB health plan coverage while enrolled in employer-sponsored medical coverage may enroll in PEBB health plan coverage by sending a completed enrollment form and proof of continuous enrollment in comprehensive employer-sponsored coverage to the PEBB program:

(i) During an annual open enrollment period (PEBB coverage will begin the first day of January after the open enrollment period); or

(ii) No later than sixty days after their employer-sponsored coverage ends. (PEBB coverage will begin the first day of the month after the employer-sponsored coverage ends.)

(b) Retirees who defer PEBB health plan coverage while enrolled as a retiree or dependent of a retiree in a federal retiree plan will have a one-time opportunity to reenroll in PEBB health plan coverage by sending a completed enrollment form and proof of continuous enrollment in a federal retiree medical plan to the PEBB program:

(i) During an annual open enrollment period (PEBB coverage will begin the first day of January after the open enrollment period); or

(ii) No later than sixty days after the federal retiree coverage ends. (PEBB coverage will begin the first day of the month after the federal retiree coverage ends.)

(c) Retirees who defer PEBB health plan coverage while enrolled in Medicare Parts A and B and Medicaid may enroll in PEBB health plan coverage by sending a completed enrollment form and proof of continuous enrollment in creditable coverage to the PEBB program:

(i) During the annual open enrollment period (PEBB coverage will begin the first day of January after the open enrollment period); or

(ii) No later than sixty days after their Medicaid coverage ends (PEBB coverage will begin the first day of the month after the Medicaid coverage ends); or

(iii) No later than the end of the calendar year during which their Medicaid coverage ends if the retiree was also determined eligible under 42 USC § 1395w-114 and subsequently enrolled in a Medicare Part D plan. (PEBB coverage will begin the first day of January following the end of the calendar year during which the Medicaid coverage ends.)

[Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-205, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-205, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-205, filed 8/26/04, effective 1/1/05.]

WAC 182-12-211 If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB sponsored insurance coverage? (1) When the Washington state department of retirement systems (DRS) makes a formal determination that a person is retroactively eligible for pension benefits, that person may apply for PEBB retiree health plan coverage only if application is made within sixty days after the date of notice from DRS.

(2) All premium due from the date of eligibility established by DRS or the date of the DRS decision letter, at the option of the retiree, must be sent with the application to HCA.

(3) The administrator may make an exception to the date PEBB retiree benefits commence or payment of premiums; however, such requests must demonstrate extraordinary circumstances beyond the control of the retiree.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-211, filed 8/26/04, effective 1/1/05.]

WAC 182-12-250 Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty. Surviving dependents of emergency service personnel who are killed in the line of duty are eligible for health plan coverage administered by the HCA.

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(1) This section applies to the dependents of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and fire fighters as defined in RCW 41.26.030, and reserve officers and fire fighters as defined in RCW 41.24.010.

(3) "Surviving dependent" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) Dependent children. The term "children" includes the following unmarried children of the emergency service worker who are: Under the age of twenty or under the age of twenty-four if he or she is a dependent student attending high school or registered at an accredited secondary school, college, university, vocational school, or school of nursing. Disabled dependents as defined in RCW 41.26.030(7) are eligible at any age. "Children" are defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren; and

(iii) Legally adopted children.

(4) Surviving dependents who are entitled to Medicare must enroll in both parts A and B of Medicare.

(5) The surviving dependent must send a completed enrollment form (to either enroll or defer public employees' benefits board (PEBB) coverage) to PEBB benefits services department no later than one hundred eighty days after the latter of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer fire fighters and reserve officers that informs the survivor that he or she is determined to be an eligible survivor;

(c) The last day the surviving dependent was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving dependent was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors that do not choose to defer PEBB coverage may choose among the following options for when their PEBB coverage will begin:

(a) June 1, 2006, for survivors whose enrollment form is received by PEBB benefit services no later than September 1, 2006;

(b) The first of the month that is no more than sixty days before the date that PEBB benefit services receives the enrollment form (for example, if PEBB benefit services receives the enrollment form on August 29, the survivor may request coverage to begin on July 1); or

(c) The first of the month after the date that PEBB benefit services receives the enrollment form.

For surviving dependents who enroll, monthly premiums for PEBB health plan coverage must be paid by the survivor except as provided in RCW 41.26.510(5).

(7) Surviving dependents must choose one of the following two options to maintain eligibility for PEBB health plan coverage:

(a) Enroll in PEBB health plan coverage:

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- (i) Enroll in medical coverage; or
- (ii) Enroll in medical and dental coverage.
- (iii) The dependent must stay enrolled in dental coverage for at least two years before dental coverage can be dropped.
- (iv) Dental only coverage is not an option.
- (b) Defer enrollment:
 - (i) Surviving dependents may defer enrollment in PEBB health plan coverage if they are enrolled in comprehensive medical coverage through an employer.
 - (ii) Surviving dependents may enroll in PEBB health plan coverage when they lose employer coverage. Dependents will need to prove they were continuously enrolled in comprehensive coverage through an employer when applying for PEBB coverage, and apply within sixty days after the date their other coverage ended.
 - (iii) PEBB health plan coverage and premiums will begin the first day of the month following the day that the other coverage ended for dependents that reenroll.
- (8) Surviving dependents may change their health plan during open enrollment. In addition to open enrollment, they may change health plans if they move out of their health plan's service area or into a service area where a health plan that was not previously offered is now available.
- (9) Surviving dependents may not add new dependents acquired through birth, marriage, or establishment of a qualified same-sex domestic partnership.
- (10) Surviving dependents will lose their right to enroll in PEBB health plan coverage if they:

(a) Do not apply to enroll or defer PEBB health plan coverage within the timelines stated in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in comprehensive coverage through an employer during the deferral period, as provided in subsection (7)(b)(i) of this section.

[Statutory Authority: RCW 41.05.160 and 41.05.080. 06-20-099 (Order 06-08), § 182-12-250, filed 10/3/06, effective 11/3/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-250, filed 8/26/04, effective 1/1/05.]

WAC 182-12-260 Eligible dependents defined. The following are eligible as dependents under the PEBB eligibility rules:

- (1) Lawful spouse.
- (2) A same sex domestic partner qualified through the declaration certificate issued by PEBB.
- (3) Dependent children through age nineteen. The term "children" includes the subscriber's biological children, step-children, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified same sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and extended dependents approved by PEBB are included. To qualify for PEBB approval, the subscriber must demonstrate legal custody for the child with a court order, and the child:
 - (a) Must be living with the subscriber in a parent-child relationship; and
 - (b) Must not be a foster child for whom support payments are made to the subscriber through the state department of social and health services (DSHS) foster care program.

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ment of social and health services (DSHS) foster care program.

(4) Dependent children age twenty through age twenty-three and who are registered students at an accredited secondary school, college, university, vocational school, or school of nursing.

(a) Dependent student coverage begins the first day of the month in which the quarter/semester for which the dependent is registered begins and ends the last day of the month in which the dependent stops attending or in which the quarter/semester ends, whichever is first, except that dependent student eligibility continues year-round for those who attend three of the four school quarters or two semesters.

(b) Dependent student coverage continues during the three month period following graduation provided the subscriber is covered, at the same time, the dependent has not reached age twenty-four, and the dependent meets all other eligibility requirements.

(5) Dependent children of any age with disabilities, developmental disabilities, mental illness or mental retardation who are incapable of self-support, provided such condition occurs prior to age twenty or during the time the dependent was eligible as a student under subsection (4) of this section. The subscriber must provide proof that such disability occurred prior to the dependent's attainment of age twenty or during the time the dependent satisfies eligibility for student coverage under subsection (4) of this section, and as periodically requested thereafter by the PEBB program.

(a) The subscriber must notify the PEBB program, in writing, no later than sixty days after the date that a dependent child age twenty or older no longer qualifies under this subsection.

(i) For example, children who become self-supporting are not eligible under this rule as of the last day of the month in which they become capable of self-support. The dependent may be eligible to continue PEBB coverage under provisions of WAC 182-12-270.

(ii) Children age twenty and older that become capable of self-support do not regain eligibility under subsection (5) of this section if they later become incapable of self-support.

(6) Dependent parents.

(a) Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous coverage in PEBB sponsored medical coverage;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of an eligible subscriber;

(iii) The subscriber who claimed the parent as a dependent continues enrollment in PEBB insurance coverage; and

(iv) The parent is not covered by any other group medical coverage.

(b) Dependent parents that are eligible under (a) of this subsection may be enrolled with a different health carrier than that selected by the eligible subscriber; however, dependent parents may not add additional dependents to their coverage.

(7) The enrollee must notify the PEBB program, in writing, no later than sixty days after the date that a dependent no longer qualifies under subsection (1), (2), (3), (4) or (6) of this section. The subscriber must notify the PEBB program in

writing no later than sixty days after the date a dependent no longer qualifies under subsection (5) of this section. A PEBB continuation of coverage election notice will only be available if the PEBB program is notified in writing within the sixty-day period.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-260, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-260, filed 8/26/04, effective 1/1/05.]

WAC 182-12-265 What options for continuing health plan coverage are available to widows, widowers and dependent children if the employee or retiree dies? The surviving dependent of an eligible employee or retiree who meets the eligibility criteria in subsection (1), (2), or (3) of this section is eligible to enroll in public employees' benefits board (PEBB) retiree coverage as a surviving dependent. An eligible surviving dependent must enroll in or defer PEBB health plan coverage no later than sixty days after the date of the employee's or retiree's death.

(1) Dependents that lose eligibility due to the death of an eligible employee may continue health plan coverage under a retiree plan provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

(a) The employee's spouse or qualified same sex domestic partner may continue coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(c) If a surviving dependent of an eligible employee is not eligible for a monthly retirement benefit (or a lump-sum payment because the monthly pension payment would be less than the minimum amount established by the department of retirement systems) the dependent is not eligible to participate in PEBB retiree coverage. However, the dependent may continue health plan coverage under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or WAC 182-12-270.

(d) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement System, shall be considered a Washington sponsored retirement system for Washington State University extension service employees who were covered under PEBB insurance coverage at the time of death.

(2) Dependents that lose eligibility due to the death of a PEBB eligible retiree may continue health plan coverage under a retiree plan.

(a) The retiree's spouse or qualified same sex domestic partner may continue coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(c) Dependents that are waiving PEBB health plan coverage at the time of the retiree's death are eligible to enroll or defer PEBB retiree coverage. A form to enroll or defer PEBB health plan coverage must be hand-delivered or mailed to the PEBB program no later than sixty days after the retiree's death. To enroll in PEBB health plan coverage, the dependent must provide satisfactory evidence that enrollment in other health plan coverage was continuous from the most recent open enrollment period for which PEBB coverage was waived.

(3) Surviving spouses or eligible dependent children of a deceased school district or educational service district employee who were not enrolled in PEBB insurance coverage at the time of the subscriber's death may enroll in PEBB sponsored health plan coverage provided the employee died on or after October 1, 1993, and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW.

(a) The employee's spouse or qualified same-sex domestic partner may continue health plan coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(4) Surviving dependents must notify the PEBB program of their decision to enroll or defer PEBB health plan coverage no later than sixty days after the date of death of the employee or retiree. If PEBB coverage ended due to the death of the employee or retiree, PEBB will reinstate health plan coverage without a gap subject to payment of premium. In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in PEBB health plan coverage under WAC 182-12-200 and 182-12-205. To notify the PEBB program of their intent to enroll or defer PEBB health plan coverage the surviving dependent must send a completed enrollment form to the PEBB program no later than sixty days after the date of death of the employee or retiree.

[Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-265, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-265, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-265, filed 8/26/04, effective 1/1/05.]

WAC 182-12-270 What options are available to dependents that cease to meet the definition of dependent in WAC 182-12-260? If eligible, dependents may continue enrollment in PEBB health plan coverage under one of the continuation options in subsection (1), (2), or (3) of this section by self-paying premiums following their loss of eligibility. PEBB must receive a timely election form as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing coverage are based on the reason that eligibility was lost.

(1) Dependents that lose eligibility due to the death of an employee or retiree may be eligible to continue coverage under provisions of WAC 182-12-265.

(2) Dependents of a lawful marriage that lose eligibility because they no longer meet the definition of dependent as defined in WAC 182-12-260 are eligible to continue coverage under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA); or

(3) Dependents of a qualified same sex domestic partnership that lose eligibility because they no longer meet the definition of dependent as defined in WAC 182-12-260 may continue under an extension of PEBB coverage for a maximum of thirty-six months.

No extension of PEBB coverage will be offered unless PEBB benefits services is notified through hand-delivery or United States Postal Service mail of a completed notice of qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-270, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-270, filed 8/26/04, effective 1/1/05.]

Chapter 182-13 WAC

STATE RESIDENT—MEDICARE SUPPLEMENT

WAC

182-13-010	Purpose.
182-13-020	Definitions.
182-13-030	Eligibility.
182-13-040	Application for Medicare supplement coverage.

WAC 182-13-010 Purpose. The purpose of this chapter is to establish criteria for state residents for participation in Medicare supplement coverage available through the HCA.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-010, filed 3/3/95, effective 4/3/95.]

WAC 182-13-020 Definitions. Unless otherwise specifically provided, the definitions contained in this section apply throughout this chapter.

(1) "HCA" means the Washington state health care authority.

(2) "Health plan," or "plan" means any individual or group: Policy, agreement, or other contract providing coverage for medical, surgical, hospital, or emergency care services, whether issued, or issued for delivery, in Washington or any other state. "Health Plan" or "plan" also includes self-insured coverage governed by the federal Employee Retirement Income Security Act, coverage through the Health Insurance Access Act as described in chapter 48.41 RCW, coverage through the Basic Health Plan as described in chapter 70.47 RCW, and coverage through the Medicaid program as described in Title 74 RCW. "Health plan" or "plan" does not mean or include: Hospital confinement indemnity coverage as described in WAC 284-50-345; disability income protection coverage as described in WAC 284-50-355; accident only coverage as described in WAC 284-50-360; specified disease and specified accident coverage as described in WAC 284-50-365; limited benefit health insurance coverage as described in WAC 284-50-370; long-term care benefits as described in chapter 48.84 RCW; or limited health care coverage such as dental only, vision only, or chiropractic only.

(3) "Lapse in coverage" means a period of time greater than ninety continuous days without coverage by a health plan.

(4) "Resident" means a person who demonstrates that he/she lives in the state of Washington at the time of application for, and issuance of coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-020, filed 3/3/95, effective 4/3/95.]

WAC 182-13-030 Eligibility. Residents are eligible to apply for Medicare supplement coverage arranged by the HCA when they are:

- (1) Eligible for Parts A and B of Medicare, and
- (2) Actually enrolled in both Parts A and B of Medicare not later than the effective date of Medicare supplement coverage.

(2007 Ed.)

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-030, filed 3/3/95, effective 4/3/95.]

WAC 182-13-040 Application for Medicare supplement coverage. Residents meeting eligibility requirements may apply for Medicare supplement coverage arranged by the HCA:

- (1) During the initial open enrollment period of January 1 through June 30, 1995, or
- (2) Within sixty days after becoming a resident, or
- (3) In the thirty day period before the resident becomes eligible for Medicare, or
- (4) Within sixty days of retirement, or
- (5) During any open enrollment period established by federal or state law, or
- (6) During any open enrollment period established by the HCA subsequent to the initial open enrollment period provided that the applicant is replacing a health plan with no lapse in coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-040, filed 3/3/95, effective 4/3/95.]

Chapter 182-16 WAC

PRACTICE AND PROCEDURE

WAC

182-16-010	Adoption of model rules of procedure.
182-16-020	Definitions.
182-16-030	Appeals from agency decisions—Applicability.
182-16-040	Appeals—Notice of appeal contents.
182-16-050	Appeals—Hearings.

WAC 182-16-010 Adoption of model rules of procedure. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by this agency. Those rules may be found in chapter 10-08 WAC. Other procedural rules adopted in this title are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in this title, the procedural rules adopted in this title shall govern.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-010, filed 6/25/91, effective 7/26/91.]

WAC 182-16-020 Definitions. As used in this chapter the term:

- (1) "Administrator" shall mean the administrator of the health care authority;
- (2) "Agency" shall mean the health care authority;
- (3) "Agent" shall mean a person, association, or corporation acting on behalf of the health care authority pursuant to a contract between the health care authority and the person, association, or corporation.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-020, filed 6/25/91, effective 7/26/91.]

WAC 182-16-030 Appeals from agency decisions—Applicability. Any enrollee of the health care authority's administered insurance plans (the self-insured plans) aggrieved by a decision of the agency or its agent concerning any matter related to scope of coverage, denials of claims,

determinations of eligibility, or cancellations or nonrenewals of coverage may obtain administrative review of such decision by filing a notice of appeal with the health care authority's appeals committee. Review of decisions made by HMOs or similar health care contractors will be pursuant to the grievance/arbitration provisions of those plans and are not subject to these rules. Except that decisions concerning eligibility determinations are reviewable only by the health care authority.

[Statutory Authority: RCW 41.05.160, 97-21-128, § 182-16-030, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250, 91-14-025, § 182-16-030, filed 6/25/91, effective 7/26/91.]

WAC 182-16-040 Appeals—Notice of appeal contents. Except as provided by RCW 48.43.530 and 48.43.535, any person aggrieved by a decision of the health care authority's PEBB program may appeal that decision by filing a notice of appeal with the PEBB program's appeals manager. The notice of appeal must contain:

- (1) The name and mailing address of the enrollee;
- (2) The name and mailing address of the appealing party;
- (3) The name and mailing address of the appealing party's representative, if any;
- (4) A statement identifying the specific portion of the decision being appealed making it clear what it is that is believed to be unlawful or unjust;
- (5) A clear and concise statement of facts in support of appealing party's position;
- (6) Any and all information or documentation that the aggrieved person would like considered and feels substantiates why the decision should be reversed (information or documentation submitted at a later date, unless specifically requested by the appeals manager, may not be considered in the appeal decision);
- (7) A copy of the PEBB program's or health carrier's response to the issue the appellant has raised;
- (8) The type of relief sought;
- (9) A statement that the appealing party has read the notice of appeal and believes the contents to be true, followed by his or her signature and the signature of his or her representative, if any;
- (10) The appealing party shall file the original notice of appeal with PEBB benefit services using hand delivery, electronic mail or United States Postal Service mail. The notice of appeal must be received by PEBB benefit services within sixty days after the decision of the PEBB staff was mailed to the appealing party. The PEBB appeals manager shall acknowledge receipt of the copies filed with PEBB benefit services;
- (11) The appeals officer will render a written decision within thirty working days after receipt of the complete notice of appeal.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-16-040, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160, 97-21-128, § 182-16-040, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250, 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-050 Appeals—Hearings. (1) If the health care authority's appeals officer upholds the original denial, the enrollee may request an administrative hearing in

writing to the PEBB program's appeals manager. PEBB benefit services must receive the written request for a hearing within fifteen days of the date the appeals decision was mailed to the appellant.

(2) The agency shall set the time and place of the hearing and give not less than seven days notice to all parties and persons who have filed written petitions to intervene.

(3) The administrator or his or her designee shall preside at all hearings resulting from the filings of appeals.

(4) All hearings shall be conducted in compliance with these rules, chapter 34.05 RCW and chapter 10-08 WAC as applicable.

(5) Within ninety days of the hearing, the administrator or his or her designee shall render a decision which shall be the final decision of the agency. A copy of that decision accompanied by a written statement of the reasons for the decision shall be served on all parties and persons who have intervened.

[Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-16-050, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160, 97-21-128, § 182-16-050, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250, 91-14-025, § 182-16-050, filed 6/25/91, effective 7/26/91.]

Chapter 182-20 WAC

STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

182-20-001	Purpose.
182-20-010	Definitions.
182-20-100	Administration.
182-20-130	Application for funds.
182-20-160	Eligibility.
182-20-200	Allocation of state funds.
182-20-300	Dispute resolution procedures.
182-20-320	Audit review.
182-20-400	Limitations on awards.
182-20-500	Dental residency pilot project.
182-20-600	Community health care collaborative program.
182-20-610	Administration.
182-20-620	Application process.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-20-250	Allocation of state noncitizen immigrant funds. [Statutory Authority: RCW 41.05.220, 02-18-089 (Order 02-04), § 182-20-250, filed 9/3/02, effective 10/1/02.] Repealed by 07-01-107 (Order 06-03), filed 12/19/06, effective 1/19/07. Statutory Authority: RCW 41.05.220.
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WAC 182-20-001 Purpose. The purpose of this chapter is to establish procedures at the Washington state health care authority for determining eligibility and distribution of funds for:

(1) Medical, dental, and migrant services to community health clinics under section 214(3), chapter 19, Laws of 1989 1st ex. sess., including other state general fund appropriations for medical, dental, and migrant services in community health clinics since 1985; and

(2) Other grant programs assigned to the authority. The authority shall disburse grant awards to community-based organizations to develop innovative health care delivery models that address:

- (a) Access to medical treatment;
- (b) Efficient use of health care resources; or

(c) Improve quality of care.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-001, filed 12/28/06, effective 1/28/07. Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-001, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-001, filed 5/26/95, effective 6/26/95.]

WAC 182-20-010 Definitions. For the purposes of these rules, the following words and phrases shall have these meanings unless the context clearly indicates otherwise.

(1) "Community health clinic" means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

(2) "Authority" means the Washington state health care authority.

(3) "Encounter" means a face-to-face contact between a patient and a health care provider exercising independent judgment, providing primary health care, and documenting the care in the individual's health record.

(4) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care including:

- (a) Physicians under chapters 18.57 and 18.71 RCW;
- (b) Dentists under chapter 18.32 RCW;
- (c) Advanced registered nurse practitioner under chapter 18.79 RCW;
- (d) Physician's assistant under chapters 18.71A and 18.57A RCW;
- (e) Dental hygienist under chapter 18.29 RCW;
- (f) Licensed midwife under chapter 18.50 RCW;
- (g) Federal uniformed service personnel lawfully providing health care within Washington state.

(5) "Low-income individual" means a person with income at or below two hundred percent of federal poverty level. The poverty level has been established by Public Law 97-35 § 652 (codified at 42 USC 9847), § 673(2) (codified at 42 USC 9902 (2)) as amended; and the *Poverty Income Guideline* updated annually in the *Federal Register*.

(6) "Primary health care" means comprehensive care that includes a basic level of preventive and therapeutic medical and/or dental care, usually delivered in an outpatient setting, and focused on improving and maintaining the individual's general health.

(7) "Relative value unit" means a standard measure of performance based upon time to complete a clinical procedure. The formula is one unit equals ten minutes. A table is available from the authority stating the actual values.

(8) "Administrator" means the administrator of the health care authority or the administrator's designee.

(9) "User" means an individual having one or more primary health care encounters and counted only once during a calendar year.

(10) "Contractor" means the community health clinic or other entity performing services funded by chapter 182-20 WAC, and shall include all employees of the contractor.

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-010, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-010, filed 5/26/95, effective 6/26/95.]

(2007 Ed.)

WAC 182-20-100 Administration. The authority shall contract with community health clinics to provide primary health care in the state of Washington by:

(1) Developing criteria for the selection of community health clinics to receive funding;

(2) Establishing statewide standards governing the granting of awards and assistance to community health clinics;

(3) Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;

(4) Distributing available state funds to community health clinics according to the following priority in the order listed:

(a) First, to community health clinics that are private, nonprofit corporations classified exempt under Internal Revenue Service Rule 501 (c)(3) and governed by a board of directors including representatives from the populations served;

(b) Second, to local health jurisdictions with an organized primary health clinic or division;

(c) Third, to private nonprofit or public hospitals with an organized primary health clinic or department.

(5) Reviewing records and conducting on-site visits of contractors or applicants as necessary to assure compliance with these rules; and

(6) Withholding funding from a contractor or applicant until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:

- (a) Noncompliance with applicable state law or rule; or
- (b) Noncompliance with the contract; or
- (c) Failure to provide such records and data required by the authority to establish compliance with section 214(3), chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or

(d) The contractor or applicant provided inaccurate information in the application.

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-100, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-100, filed 5/26/95, effective 6/26/95.]

WAC 182-20-130 Application for funds. (1) The authority shall, upon request, supply a prospective applicant with an application kit for a contract requesting information as follows:

(a) Include in the application a request for information as follows:

- (i) The applicant's name, address, and telephone number;
- (ii) A description of the primary health care provided;
- (iii) A brief statement of intent to apply for funds;
- (iv) The signature of the agency's authorized representative;

(v) Description of the nature and scope of services provided or planned;

(vi) Evidence of a current financial audit establishing financial accountability; and

(vii) A description of how the applicant meets eligibility requirements under WAC 182-20-160;

(b) Notify existing contractors at least ninety days in advance of the date a new contract application is due to the authority;

- (c) Review completed application kits for evidence of compliance with this section;
- (d) Develop procedures for:
 - (i) Awarding of funds for new contractors, special projects, and emergency needs of existing contractors; and
 - (ii) Notifying existing and prospective contractors of procedures and application process.
- (2) The applicant shall:
 - (a) Complete the application on standard forms provided or approved by the authority; and
 - (b) Return the completed application kit to the authority by the specified due date.

[Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-130, filed 5/26/95, effective 6/26/95.]

WAC 182-20-160 Eligibility. Applicants shall:

- (1) Demonstrate private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local or county government;
- (2) Receive other funds from at least one of the following sources:
 - (a) Section 329 of the Public Health Services Act;
 - (b) Section 330 of the Public Health Services Act;
 - (c) Community development block grant funds;
 - (d) Title V Urban Indian Health Service funds; or
 - (e) Other public or private funds providing the clinic demonstrates:
 - (i) Fifty-one percent of total clinic population are low income;
 - (ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;
- (3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;
- (4) Provide primary health care services with:
 - (a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;
 - (b) Direct clinical services provided by one or more of the following:
 - (i) Physician licensed under chapters 18.57 and 18.71 RCW;
 - (ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;
 - (iii) Advanced registered nurse practitioner under chapter 18.79 RCW;
 - (iv) Dentist under chapter 18.32 RCW;
 - (v) Dental hygienist under chapter 18.29 RCW;
 - (c) Provision or arrangement for services as follows:
 - (i) Preventive health services on-site or elsewhere including:
 - (A) Eye and ear examinations for children;
 - (B) Perinatal services;
 - (C) Well-child services; and
 - (D) Family planning services;
 - (ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;
 - (iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;

- (iv) Diagnostic laboratory and radiological services on-site or elsewhere;
- (v) Emergency medical services on-site or elsewhere;
- (vi) Arrangements for transportation services;
- (vii) Preventive dental services on-site or elsewhere; and
- (viii) Pharmaceutical services, as appropriate, on-site or elsewhere;
- (5) Demonstrate eligibility to receive and receipt of reimbursement from:
 - (a) Public insurance programs; and
 - (b) Public assistant programs, where feasible and possible;
- (6) Have established for at least eighteen months an operating sliding scale fee schedule for adjustment of charges, based upon the individual's ability to pay for low-income individuals;
- (7) Provide health care regardless of the individual's ability to pay; and
- (8) Establish policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served and provide sufficient staff with the ability to communicate with the individuals.

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-160, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-160, filed 5/26/95, effective 6/26/95.]

WAC 182-20-200 Allocation of state funds. The authority shall allocate available funds to medical, dental and migrant contractors providing primary health care based on the following criteria:

(1) Medical.

- (a) The authority may withhold appropriated funds as follows:
 - (i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:
 - (A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;
 - (B) Prorated according to the percentage of total medical contract funds distributed to each contractor;
 - (ii) Up to ten percent for administration.
- (b) The remainder of the appropriated funds is referred to as the "medical base." The medical base means the total amount of money appropriated by the legislature for the medical program minus the amounts specified in (a)(i) and (ii) of this subsection. The medical base is distributed to medical contractors based upon the following formulas:
 - (i) Starting July 1, 1996, the medical base is distributed to medical contractors based upon the following formula:
 - (A) Forty percent of the medical base is distributed equally among all medical contractors;
 - (B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee users
 _____ X 30% medical base
 total of all contractors' medical sliding fee users

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee encounters by the total number of medical sliding fee encounters reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee encounters
 _____ X 30% medical base

total of all contractors' medical sliding fee encounters

(2) Dental.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent of appropriated funds to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total dental contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the funds is referred to as the dental base. The dental base means the total amounts appropriated by the legislature for dental programs minus the amounts specified in (a)(i) and (ii) of this subsection and as follows:

(i) Starting July 1, 1996, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee users
 _____ X 30% dental base

total of all contractors' dental sliding fee users

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee relative value units (RVU) divided by the total number of dental sliding fee relative value units (RVU) reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee RVUs
 _____ X 30% dental base

total of all contractors' dental sliding fee RVUs

(3) Migrant.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total migrant contract funds distributed to each contractor.

(2007 Ed.)

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "migrant base." The migrant base means the total amount of money appropriated by the legislature for the migrant program minus the amounts specified in (a)(i) and (ii) of this subsection. The migrant base is distributed to migrant contractors based upon the following formula:

The migrant base is distributed to migrant contractors based upon the following formula starting July 1, 1995: One hundred percent of the migrant base is distributed by the ratio of the contractor's primary health care (PHC) migrant users divided by the total migrant users of all contractors as reported in the prior calendar year annual reports.

individual contractor's migrant users
 _____ X 100% migrant base

total of all contractors' migrant users

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-200, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-200, filed 5/26/95, effective 6/26/95.]

WAC 182-20-300 Dispute resolution procedures. The authority shall define dispute resolution procedures in the contract which shall be the exclusive remedy and shall be binding and final to all parties.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-300, filed 5/26/95, effective 6/26/95.]

WAC 182-20-320 Audit review. Contractors shall:

(1) Maintain books, records, documents, and other materials relevant to the provision of goods or services adequate to document the scope and nature of the goods or services provided;

(2) Make the materials in subsection (1) of this section available at all reasonable times with prior notice for inspection by the authority;

(3) Retain these materials for at least three years after the initial contract with the authority;

(4) Provide access to the facilities at all reasonable times with prior notice for on-site inspection by the authority; and

(5) Submit annual reports consistent with the instructions of the authority.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-320, filed 5/26/95, effective 6/26/95.]

WAC 182-20-400 Limitations on awards. Specific to the medical, dental, and migrant base as referenced in WAC 182-20-200 (1)(b), (2)(b), and (3)(b):

Starting July 1, 1997:

(1) Any approved contractor shall initially receive funding based on no more than a ratio of one hundred twenty-five percent of that contractor's previous year's initial allotment.

(2) Any approved contractor shall initially receive funding based on no less than a ratio of seventy-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide seventy-five percent, criteria shall be established to equitably allocate the available funds.

(3) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

Starting July 1, 2004:

(4) Funds distributed pursuant to WAC 182-20-200 (1)(b)(i)(A) and (2)(b)(i)(A), the forty percent base, shall be limited to no more than \$30,000.

Funds distributed in excess of the \$30,000 limitation shall be added to the appropriate medical formulae in WAC 182-20-200 (1)(b)(i)(B) and (C), or dental formulae in WAC 182-20-200 (2)(b)(i)(B) and (C), productivity portions of the funding formulae.

[Statutory Authority: RCW 41.05.220, 04-03-006 (Order 03-03), § 182-20-400, filed 1/8/04, effective 2/8/04. Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-400, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-400, filed 5/26/95, effective 6/26/95.]

WAC 182-20-500 Dental residency pilot project. (1)

The provisions of this section apply to organizations that wish to apply for funding to operate a dental residency program pursuant to the provisions of RCW 18.32.040.

(2) The authority will, upon request, supply to interested parties the application forms and information needed to apply for funding for a dental residency program.

(3) The forms shall require applicants to provide the following information:

(a) The applicant's name, address, and telephone number;

(b) A full description of the dental residency program to be funded;

(c) A brief statement of intent to apply for funding.

(4) Clinics that wish to apply for funding must meet the following criteria:

(a) Have American Dental Association (ADA) accreditation;

(b) Comply with the department of health's dental residency licensure requirements; and

(c) Operate a one-year advanced education in general dentistry residency (AEGD) program.

(5) The authority will allocate funds pursuant to written procedures which may be updated annually. The authority will, upon request, supply a copy of the allocation procedures to interested parties.

[Statutory Authority: RCW 41.05.220, 06-07-101 (Order 05-07), § 182-20-500, filed 3/15/06, effective 7/1/06.]

WAC 182-20-600 Community health care collaborative program. The community health care collaborative grant program was established July 1, 2006, to develop innovative health care delivery models. The funding covers a two-year cycle; half of the award to be distributed throughout the first year and the final half distributed throughout the second year upon evidence of successful program progress and achieving grant objectives, based upon available funding.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-600, filed 12/28/06, effective 1/28/07.]

WAC 182-20-610 Administration. The authority is responsible for:

(1) Preaward development.

(a) Develop criteria for the selection of community-based organizations to receive grant funding;

(b) Develop equitable standards governing the granting of awards;

(c) Determine nature and format of the application and process.

(2) Award determinations.

(a) Consult with representatives, appointed by the secretary of the department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and the office of the insurance commissioner to make recommendations for final applicant selection and grant determination;

(b) The administrator will review recommendations and make final determination based upon recommendations, funds available and utilization of resources to meet the goals of the program;

(c) Conduct on-site visits to ensure applicant's ability to achieve grant objectives and performance measures identified in the application;

(d) Contract with successful applicants; and

(e) Disburse grant funds according to program policy.

(3) Post-award actions.

(a) Review periodic progress reports from contractors;

(b) Conduct on-site visits of contractors to provide assistance and ensure compliance of grant objectives;

(c) Consult with representatives from department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and office of the insurance commissioner, one year following initial disbursement, to make recommendations to administrator for disbursement of the second half of grant funds, based upon performance measures identified in the application and evidence of successful program progress and achieving grant objectives;

(d) The administrator will review and make final determination for grant disbursements; and

(e) Compile a report to the governor and legislature on July 1, 2008, which:

(i) Describes organizations and programs funded;

(ii) Describes and analyzes results achieved;

(iii) Makes recommendations for improvements to the program; and

(iv) Highlights best practices that can be replicated statewide.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-610, filed 12/28/06, effective 1/28/07.]

WAC 182-20-620 Application process. (1) Eligibility.

(a) Applicants must provide the following in the application format prescribed by the authority:

(i) Evidence of private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local, county, or tribal government;

(ii) Evidence of the specific geographic region served and a formal collaborative governing structure by documentation that may include, but is not limited to:

(A) Bylaws;

(B) Agreements;

(C) Contracts;

(D) Memorandum of understanding;

- (E) Minutes;
- (F) Letters; or
- (G) Other communications;
- (iii) Amount of funds requested and how the dollars will be spent;
- (iv) Data to evaluate program progress and grant objectives.
- (b) Applicants will be evaluated competitively on their ability to:
 - (i) Address documented health care needs in the specific region served;
 - (ii) Engage key community members;
 - (iii) Show evidence of matching funds of at least two dollars for each grant dollar requested. All matching fund contributions, including cash and in-kind, shall meet the criteria determined by the administrator and included in the application guidelines;
 - (iv) Ability to meet the documented health care needs and address sustainability of programs;
 - (v) Show innovation in program approaches that could be replicated throughout the state;
 - (vi) Make efficient and cost-effective use of funds by simplifying administration affecting the health care delivery system;
 - (vii) Clearly describe size of organization, program objectives, and populations served; and
 - (viii) Meet the reporting requirements of the authority.
- (c) Application access.
 - (i) The call for grant applications will be made by posting the announcement to the authority's official web site and by notification sent to interested parties.
 - (ii) To be placed on the interested parties distribution list, send contact information, including mailing and e-mail addresses to community health care collaboration at Washington State Health Care Authority, P.O. Box 42721, Olympia, Washington 98504-2721.

(2) The guidelines and application forms will be available on the authority's official web site and included with the published guidelines distributed by e-mail to those who request an application. The application will be available in hard copy and sent by United States mail upon request. Applications must be completed and submitted in the format and filed by the deadlines prescribed by the authority and published in the guidelines.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-620, filed 12/28/06, effective 1/28/07.]

Chapter 182-25 WAC

WASHINGTON BASIC HEALTH PLAN

WAC

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182-25-110	How to appeal a managed health care system (MHCS) decision.
182-25-120	Basic health plan coverage for health coverage tax credit eligible enrollees.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-25-031	Transition coverage. [Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-031, filed 11/18/99, effective 12/19/99.] Repealed by 03-24-041 (Order 03-04), filed 11/26/03, effective 12/27/03. Statutory Authority: RCW 70.47.050.
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WAC 182-25-001 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-001, filed 7/9/96, effective 8/9/96.]

WAC 182-25-010 Definitions. The following definitions apply throughout these rules.

(1) "Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

(2) "Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction.

(3) "Basic health plan" (or "BHP") means the system of enrollment and payment for basic health care services administered by the administrator through managed health care systems.

(4) "BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and basic health plan. Eligibility for BHP Plus is determined by the department of social and health services, based on Medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for Medicare, and may be required to meet additional DSHS eligibility requirements.

(5) "Co-payment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the MHCS.

(6) "Covered services" means those services and benefits in the BHP schedule of benefits (as outlined in the member handbook issued to the enrollee, or to a subscriber on behalf of the enrollee), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, coinsurance and deductible.

(7) "Disenrollment" means the termination of coverage for a BHP enrollee.

(8) "Effective date of enrollment" means the first date, as established by BHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

(9) "Dependent," as it applies to the subsidized or non-subsidized programs, means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is:

(i) Younger than age nineteen, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(ii) Younger than age twenty-three, and a registered student at an accredited secondary school, college, university, technical college, or school of nursing, attending full time, other than during holidays, summer and scheduled breaks; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) An unmarried child younger than age nineteen who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support; and

(iv) The child must be on the account for BHP coverage.

(10) "Eligible full-time employee" means an employee who meets all eligibility requirements in WAC 182-25-030 and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

(11) "Eligible part-time employee" means an employee who meets all the criteria in subsection (10) of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

(12) "Employee" means one who is in the employment of an employer, as defined by RCW 50.04.080.

(13) "Employer" means an enterprise licensed to do business in Washington state, as defined by RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

(14) "Enrollee" means a person who meets all applicable eligibility requirements, who is enrolled in BHP, and for whom applicable premium payments have been made.

(15) "Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment in BHP, an individual cannot be a member of more than one family.

(16) "Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

(17) "Gross family income" means total cash receipts, as defined in (a) of this subsection, before taxes, from all sources, for subscriber and dependents whether or not they are enrolled in BHP, with the exceptions noted in (b) of this subsection. An average of documented income received over a period of several months will be used for purposes of eligibility determination, unless documentation submitted confirms a change in circumstances so that an average would not be an accurate reflection of current income. A twelve-month average will be used when calculating gambling income, lump-sum payments, and income from capital gains. A twelve-month history of receipts and expenses will be required for calculating self-employment or rental income unless the applicant or enrollee has not owned the business for at least twelve months.

(a) Income includes:

(i) Wages, tips and salaries before any deductions;

(ii) Net receipts from nonfarm self-employment (receipts from a person's own business, professional enterprise, or partnership, after deductions for business expenses). A net loss from self-employment will not be used to offset other income sources. In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, except that:

(A) A deduction for business use of the home may be allowed in cases where the enrollee has documented that more than fifty percent of their home is used for the business for the majority of the year; or

(B) A deduction for business use of the home may be allowed in cases where the enrollee has documented that they maintain a separate building located on the same property as their home that is used exclusively for the business;

(iii) Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or share-cropper, after deductions for farm operating expenses). In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, and a net loss from self-employment will not be used to offset other income sources;

(iv) Periodic payments from Social Security, railroad retirement, military pension or retirement pay, military disability pensions, military disability payments, government employee pensions, private pensions, unemployment compensation, workers' compensation, and strike benefits from union funds;

(v) Payments for punitive damages;

(vi) Public assistance, alimony, child support, and military family allotments;

(vii) Work study, assistantships, or training stipends;

(viii) Dividends and interest accessible to the enrollee without a penalty for early withdrawal;

(ix) Net rental income, net royalties, and net gambling or lottery winnings;

(x) Lump sum inheritances and periodic receipts from estates or trusts; and

(xi) Short-term capital gains, such as from the sale of stock or real estate.

(b) Income does not include the following types of money received:

(i) Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car;

(ii) Tax refunds, gifts, loans, one-time insurance payments, other than for punitive damages, and one-time payments or winnings received more than one month prior to application;

(iii) Noncash receipts, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, goods or services received due to payments a trust makes to a third party, and such noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, state supplementary payment income that is specifically dedicated to reimburse for services received, and housing assistance;

(iv) Income earned by dependent children with the exception of distributions from a corporation, partnership, or business;

(v) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(vi) College or university scholarships, grants, and fellowships;

(vii) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145;

(viii) Long-term capital gains;

(ix) Crime victims' compensation;

(x) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction:

(A) The subscriber and the spouse listed as a dependent on the account, if any, must be employed or attending school full-time during the time the child care expenses were paid; and

(B) Payment may not be paid to a parent or stepparent of the child or to a dependent child of the subscriber or his/her spouse.

(18) "Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, Medicaid Personal Care, Community Options Program Entry System (COPES) or Respite Care (up to level three).

(19) "Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and

municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions; government-funded acute health care or mental health facilities except as provided above; chemical dependency facilities; and nursing homes.

(20) "Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in subsection (19) of this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

(21) "Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

(22) "Managed health care system" (or "MHCS") means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide basic health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(23) "Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on Medicaid eligibility criteria.

(24) "Medicaid" means the Title XIX Medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

(25) "Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

(26) "Nonsubsidized enrollee" or "full premium enrollee" means an individual who enrolls in BHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in BHP, without subsidy from the HCA.

(27) "Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

(28) "Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage under BHP.

(29) "Participating employer" means an employer who has been approved for enrollment in BHP as an employer group.

(30) "Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment in BHP:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

(31) "Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes to BHP for enrollment in BHP.

(32) "Program" means subsidized BHP, nonsubsidized BHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within this chapter.

(33) "Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

(34) "Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a managed health care system, to provide BHP health care benefits to enrollees.

(35) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, as described in the member handbook.

(36) "Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

(37) "Subscriber" is a person who applies to BHP on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom BHP sends notices and communications. The subscriber may be a BHP enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

(38) "Subsidized enrollee" or "reduced premium enrollee" means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA. Full-time students who have received a temporary visa to study in the United States are not eligible to enroll as subsidized enrollees. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human

Services, and who receives a premium subsidy from the HCA.

(39) "Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(40) "Washington state resident" or "resident," for purposes of this chapter, means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who meet the requirements of subsection (9)(b)(ii) of this section and are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

[Statutory Authority: RCW 70.47.050, 06-11-158 (Order 05-06), § 182-25-010, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188, 05-17-078 (Order 05-03), § 182-25-010, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-010, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050, 70.47.020(4) and 70.47.060 (5) and (9), 03-18-039 (Order 02-01), § 182-25-010, filed 8/27/03, effective 10/1/03. Statutory Authority: RCW 70.47.050, 70.47.020 (4) and (5), 70.47.060 (9) and (10), 74.08A.100 and 2002 c 371, 02-24-051 (Order 02-06), § 182-25-010, filed 12/3/02, effective 1/1/03. Statutory Authority: RCW 70.47.050, 01-09-001 (Order 00-08), § 182-25-010, filed 4/4/01, effective 5/5/01. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067, 01-01-134 (Order 00-04), § 182-25-010, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-010, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060(9) and SHB 2556, 98-15-018, § 182-25-010, filed 7/6/98, effective 8/6/98. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-010, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

WAC 182-25-020 BHP benefits. (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, limited mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The Medicaid scope of benefits may be provided by BHP as the BHP plus program through coordination with DSHS for children under the age of nineteen, who are found to be Medicaid eligible. BHP benefits may

include co-payments, waiting periods, limitations and exclusions which the administrator determines are appropriate and consistent with the goals and objectives of the plan. BHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under BHP. Similar coverage includes BHP; all DSHS programs administered by the medical assistance administration which have the Medicaid scope of benefits; the DSHS program for the medically indigent; Indian health services; most coverages offered by health carriers; and most self-insured health plans. A list of BHP benefits, including co-payments, waiting periods, limitations and exclusions, will be provided to the subscriber.

(2) In designing and revising BHP benefits, the administrator will consider the effects of particular benefits, co-payments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in BHP, each applicant will be given a written description of covered benefits, including all co-payments, waiting periods, limitations and exclusions, and be advised how to access information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given service area.

(4) BHP will mail to all subscribers written notice of any changes in the scope of benefits provided under BHP, or program changes that will affect premiums and co-payments at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. This subsection does not apply to premium changes that are the result of changes in income or family size. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

[Statutory Authority: RCW 70.47.050 and 70.47.090. 02-19-053 (Order 01-08), § 182-25-020, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050 and 70.47.060. 00-23-037, § 182-25-020, filed 11/9/00, effective 1/1/01. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-020, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-020, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-020, filed 7/9/96, effective 8/9/96.]

WAC 182-25-030 Eligibility. (1) To be eligible for enrollment in BHP, unless otherwise specified elsewhere in this chapter, an individual must be a Washington state resident who is not:

(a) Eligible for free Medicare coverage or eligible to buy Medicare coverage; or

(b) Institutionalized at the time of enrollment.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who is no longer a Washington resident, who becomes eligible for free or purchased Medicare, or who is later deter-

mined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled from the plan as provided in WAC 182-25-090. An enrollee who was not confined to an institution at the time of enrollment, who is subsequently confined to an institution, will not be disenrolled, provided he or she remains otherwise eligible and continues to make all premium payments when due.

(3) Eligibility for BHP Plus and maternity benefits through medical assistance is determined by DSHS, based on Medicaid eligibility criteria.

(4) For subsidized enrollment in BHP, an individual must meet the eligibility criteria in subsection (1) of this section and the definition of "subsidized enrollee" in WAC 182-25-010(38), and must pay, or have paid on his or her behalf, the monthly BHP premium.

(5) To be eligible for nonsubsidized enrollment in BHP, an individual may have any income level, must meet the eligibility criteria in subsection (1) of this section, and must pay, or have paid on their behalf, the full costs for participation in BHP, including the cost of administration, without subsidy from the HCA.

(6)(a) An individual otherwise eligible for enrollment in BHP as a subsidized enrollee may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP, or would result in an overexpenditure of BHP funds. An individual otherwise eligible for enrollment in either the subsidized or nonsubsidized program may also be denied enrollment if no MHCS is accepting new enrollment in that program or from the geographic area where the applicant lives.

(b) If the administrator closes or limits subsidized enrollment, to the extent funding is available, BHP will continue to accept and process applications for subsidized enrollment from:

(i) Children eligible for subsidized BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus for reasons other than noncompliance;

(ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-25-060;

(iii) Eligible individual home care providers;

(iv) Licensed foster care workers;

(v) Limited enrollment of new employer groups;

(vi) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and

(vii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-25-090 after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or

returning members of federally recognized native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited subsidized enrollment, applicants for subsidized BHP who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

[Statutory Authority: RCW 70.47.050 and 2006 c 343, 06-18-055 (Order 06-05), § 182-25-030, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-030, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067, 01-01-134 (Order 00-04), § 182-25-030, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-030, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060, 99-16-022 (Order 99-02), § 182-25-030, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-030, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-030, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-030, filed 7/9/96, effective 8/9/96.]

WAC 182-25-040 Enrollment in the plan. (1) Any individual applying for enrollment in BHP must submit a signed, completed BHP application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or guardian, who shall also be held responsible for payment of premiums due on behalf of the child. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook. Applications for BHP Plus enrollment on behalf of children under the age of nineteen will be referred to the department of social and health services for Medicaid eligibility determination.

(2) Each applicant for subsidized enrollment or BHP Plus must list all eligible dependents, whether or not the dependents will be enrolled, and must supply other information and documentation as required by BHP and, where applicable, DSHS medical assistance.

(a) Applicants for subsidized enrollment must provide documentation showing the amount and sources of their gross family income. Income documentation must include a copy of the applicant's most recently filed federal income tax form or verification of nonfiling status, and copies of pay stubs or other documents showing income for the most recent thirty days or complete calendar month as of the date of application. Applicants who were not required to file a federal income tax return may be required to provide other documentation showing year-to-date income. As described in WAC 182-25-010(17), BHP may use an average of documented income when determining eligibility.

(b) Applicants for subsidized or nonsubsidized enrollment must provide documentation of Washington state residence, displaying the applicant's name and current address, for example, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does

not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

(c) BHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility or MHCS selection.

(d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in BHP. Intentional submission of false information will result in disenrollment of the subscriber and all enrolled dependents.

(3) Each member may be enrolled in only one BHP account. Each family applying for enrollment must designate a MHCS from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same MHCS (with the exception of cases in which a subscriber who is paying for BHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of a MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the BHP member handbook. Generally, enrollees may change from one MHCS to another only during open enrollment or if they are able to show good cause for the transfer, for example, when enrollees move to an area served by a different MHCS or where they would be billed a higher premium for their current MHCS.

(4) When a MHCS assists BHP applicants in the enrollment process, it must provide them with the toll-free number for BHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(5) If specific funding has been appropriated for that purpose, insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed BHP's training program, will be paid a commission for assisting eligible applicants to enroll in BHP.

(a) Individual policy commission: Subject to availability of funds, and as a pilot program, BHP will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP to an eligible individual applicant if that applicant has not been a BHP member within the previous five years.

(b) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of BHP group coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(c) Insurance brokers or agents must provide the prospective applicant with the BHP toll-free information number and inform them of BHP benefits, limitations, exclusions, waiting periods, co-payments, all MHCSs available to the applicant within his/her county of residence and the estimated premium for each of them.

(d) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP, except they will not be required to be appointed by the MHCS.

(e) BHP will not pay renewal commissions.

(6) Except as provided in WAC 182-25-030(7), applications for enrollment will be reviewed by BHP within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

(7)(a) Eligible applicants will be enrolled in BHP in the order in which their completed applications, including all required documentation, have been received by BHP, provided that:

(i) At least one MHCS is accepting new enrollment in the program for which the applicant is applying and from the geographic area where the applicant lives; and

(ii) The applicant also remits full payment of the first premium bill to BHP by the due date specified by BHP.

(b) In the event a waiting list is implemented, eligible applicants will be enrolled in accordance with WAC 182-25-030(6).

(8) An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

(9) Not all family members are required to apply for enrollment in BHP; however, any family member for whom application for enrollment is not made at the same time that other family members apply, may not subsequently enroll as a family member until the next open enrollment period, unless the subscriber has experienced a "qualifying change in family status." "Qualifying changes in family status" include:

(a) The loss of other health care coverage, for a family member who has previously waived coverage, provided BHP receives the family member's application within thirty days of the loss of other coverage, along with proof of the family member's continuous medical coverage from the date the subscriber enrolled in BHP;

(b) Marriage or assuming custody or dependency of a child or adult dependent (other than newborn or newly adopted children), provided BHP receives the new family member's application within thirty days of the change in family status;

(c) Addition of an eligible newborn child or a child newly placed for adoption provided BHP receives the child's application for enrollment within sixty days of the date of birth or placement for adoption. These children may be enrolled effective from the date of birth or placement for adoption; or

(d) Addition of a family member who was not previously eligible for coverage, and who has become eligible.

(10) Subscribers must notify BHP of any changes that could affect their eligibility or subsidy or their dependents' eligibility or subsidy:

(a) Within thirty days of the end of the first month of receiving an increased income; or

(b) Within thirty days of a change other than an income change (for example, a change in family size or address).

(11) BHP will verify the continuing eligibility of subsidized enrollees through the recertification process at least once every twelve months. Upon request of BHP, subsidized

enrollees must submit evidence satisfactory to BHP, proving their continued eligibility for enrollment and for the premium subsidy they are receiving.

(a) BHP will verify income of subsidized enrollees through comparison with other state and federal agency records or other third-party sources.

(b) If the enrollee's income on record with other agencies or third-party source differs from the income the enrollee has reported to BHP, or if questions arise concerning the documentation submitted, BHP will require updated documentation from the enrollee to prove continued eligibility for the subsidy they are receiving. At that time, BHP may also require updated documentation of residence to complete the recertification process.

(c) Subsidized enrollees who have been enrolled in BHP six months or more and have not provided updated income documentation for at least six months will be required to submit new income documentation if their wage or salary income cannot be compared to an independent source for verification.

(d) Enrollees who have documented that they are not required to file a federal income tax return for previous years will not be required to provide additional verification of non-filing unless their circumstances appear to have changed or other information received indicates they have filed a federal income tax return.

(12) In addition to verification of income, subsidized and nonsubsidized enrollees must annually submit documentation satisfactory to BHP of the following:

(a) Washington state residence;

(b) Full-time student status for dependent students age nineteen through twenty-two; and

(c) Medicare ineligibility for enrollees age sixty-five or over.

(13) When determining eligibility for subsidized enrollment, noncitizens may be required to provide proof of immigration status, to verify whether they are here on a temporary visa to study in the United States.

(14) For good cause such as, but not limited to, when information received indicates a change in income or a source of income the enrollee has not reported, BHP may require enrollees to provide verification required in subsections (11) and (12) of this section more frequently, regardless of the length of time since their last recertification.

(15) Enrollees who fail to comply with a recertification request will be disenrolled, according to the provisions of WAC 182-25-090 (2)(e).

(16) If, as a result of recertification, BHP determines that an enrollee has not reported income or income changes accurately, the enrollee will be subject to the provisions of WAC 182-25-085.

[Statutory Authority: RCW 70.47.050, 06-11-158 (Order 05-06), § 182-25-040, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188, 05-17-078 (Order 05-03), § 182-25-040, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-040, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050, 04-15-109 (Order 04-05), § 182-25-040, filed 7/20/04, effective 8/20/04. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5), 02-19-054 (Order 01-07), § 182-25-040, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-040, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060, 99-16-022 (Order 99-02), § 182-25-040, filed 7/26/99, effective

8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-040, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-040, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-040, filed 7/9/96, effective 8/9/96.]

WAC 182-25-050 Employer groups. (1) BHP will accept applications for group enrollment in BHP from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies (see WAC 182-25-060(2)), the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees in the basic health plan, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" will be defined as a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of BHP managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP and to notify BHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP group membership to individual account(s).

(7) Employees enrolling in BHP must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-050, filed 7/9/96, effective 8/9/96.]

WAC 182-25-060 Home care agencies. BHP will accept applications from home care agencies under contract with department of social and health services (DSHS) for group enrollment in BHP, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups, WAC 182-25-050, with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in the basic health plan, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-25-050(5).

(5) Individual home care providers may enroll in BHP as individuals.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-060, filed 7/9/96, effective 8/9/96.]

WAC 182-25-070 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) BHP may require a minimum financial contribution from financial sponsors who are paid to deliver BHP services. Sponsors who meet the following criteria will be exempt from the minimum contribution:

(a) Organizations that are not paid to perform any function related to the delivery of BHP services, and do not receive contributions from other organizations paid to deliver BHP services;

(b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BHP services, who receive contributions from other individuals or organizations who may be paid to deliver BHP services, if the organization can demonstrate all of the following:

(i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BHP services);

(ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);

(iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and

(iv) There is no direct financial gain to the sponsoring entity.

(c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BHP services, if the organization can demonstrate all of the following:

(i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;

(ii) There is organizational and financial autonomy (the organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BHP services);

(iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BHP services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and

(iv) There is no direct financial gain to the sponsoring entity.

(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. It is the financial sponsor's responsibility to collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP and to notify BHP of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, it is the responsibility of the financial sponsor to notify sponsored enrollees and BHP if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP toll-free information number.

(8) BHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

[Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-070, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-070, filed 7/9/96, effective 8/9/96.]

WAC 182-25-080 Premiums and co-payments. (1)

Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

(2) The amount of premium due from or on behalf of a subsidized enrollee will be based upon the subscriber's gross family income, the managed health care system selected by the subscriber, rates payable to managed health care systems, and the number and ages of individuals in the subscriber's family.

(3) Once BHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by BHP unless the premium has been paid by the due date given. Thereafter, BHP will bill each subscriber or employer or financial sponsor monthly.

(4) Full payment for premiums due must be received by BHP by the date specified on the premium statement. If BHP does not receive full payment of a premium by the date specified on the premium statement, BHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the sub-

scriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for nonpayment under the provisions of WAC 182-25-090(2). Partial payment of premiums due, payment which for any reason cannot be applied to the correct BHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required co-payment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS. Repeated failure to pay co-payments, coinsurance, or other cost-sharing in full on a timely basis may result in disenrollment, as provided in WAC 182-25-090(2).

[Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-080, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.090, 02-19-053 (Order 01-08), § 182-25-080, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-080, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-080, filed 7/9/96, effective 8/9/96.]

WAC 182-25-085 Enrollees' failure to report correct income. (1) If BHP determines that the enrollee has received a subsidy overpayment due to failure to report income correctly, BHP may:

(a) Bill the enrollee for the amount of subsidy overpaid by the state; or

(b) If the overpayment was due to fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine the premium, impose civil penalties of up to two hundred percent of the subsidy overpayment.

(2) Any BHP determination under subsection (1) of this section is subject to the enrollee appeal provisions in WAC 182-25-105.

(3) When a decision under subsection (1)(a) of this section is final, BHP may establish a payment schedule and, for enrollees who remain enrolled in BHP, will collect the amount owed through future premium statements. Enrollees who disenroll prior to paying the full amount of the subsidy overpayment may continue the payment plan previously approved by BHP or may be billed for the entire amount due. BHP may charge interest for the amount past due, at the rate specified under RCW 43.17.240 and rules promulgated thereunder. The payment schedule will be for a period of no more than six months, unless BHP approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, BHP will send the enrollee advance written notice of the schedule and the total amount due. The total amount due each month will include the regular monthly premium plus charges for subsidy overpayment. If an enrollee does not pay the amount due, including charges for subsidy overpayment, the enrollee and all family members enrolled on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(b).

(4) When a final decision is made under subsection (1)(b) of this section, BHP will send the enrollee notice that payment of the civil penalty is due in full within thirty days

after the decision becomes final, unless BHP approves a different due date at the enrollee's request. If the enrollee does not pay the civil penalty by the due date, the enrollee and all family members on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(c).

(5) Individuals who are disenrolled from BHP may not reenroll until charges for subsidy overpayments or civil penalties imposed under subsection (1) of this section have been paid or BHP has approved a payment schedule and all other requirements for enrollment have been met.

(6) BHP will take all necessary and appropriate administrative and legal actions to collect the unpaid amount of any subsidy overpayment or civil penalty, including recovery from the enrollee's estate.

(7) Enrollees under employer group or financial sponsor group coverage who do not follow the income reporting procedures established by BHP and their employer or financial sponsor may be billed directly by BHP for subsidy overpayments or civil penalties assessed under subsection (1) of this section. Enrollees who do not pay the amount due will be disenrolled under WAC 182-25-090 (2)(b) or (c). Enrollees who are disenrolled for nonpayment of a subsidy overpayment or civil penalties will be excluded from the minimum participation calculation for employer groups under WAC 182-25-050(2).

[Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-085, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090. 99-12-033 (Order 99-01), § 182-25-085, filed 5/26/99, effective 6/26/99.]

WAC 182-25-090 Disenrollment from BHP. (1) An enrollee or employer group may disenroll effective the first day of any month by giving BHP at least ten days prior notice of the intention to disenroll.

(2) BHP may disenroll any enrollee or group from BHP for good cause, which includes:

(a) Failure to meet the eligibility requirements set forth in WAC 182-25-030, 182-25-050, 182-25-060, and 182-25-070;

(b) Nonpayment of premium under the provisions of subsection (6) of this section;

(c) Changes in MHCS or program availability when the enrollee's MHCS will no longer be available to him or her and no other MHCS in the area where the enrollee lives is accepting new enrollment in the enrollee's program;

(d) Repeated failure to pay co-payments, coinsurance, or other cost-sharing in full on a timely basis;

(e) Fraud, intentional misrepresentation of information or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to provide requested verification of eligibility or income, or knowingly providing false information;

(f) Abuse or intentional misconduct;

(g) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and

(h) Refusal to accept or follow procedures or treatment determined by a MHCS to be essential to the health of the enrollee, when the MHCS has advised the enrollee and demonstrated to the satisfaction of BHP that no professionally

acceptable alternative form of treatment is available from the MHCS.

(3) In addition to being disenrolled, any enrollee who knowingly provides false information to BHP or to a participating managed health care system may be held financially responsible for any covered services fraudulently obtained through BHP.

(4) At least ten days prior to the effective date of disenrollment under subsection (2)(a) and (c) through (h) of this section, BHP will send enrollees written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

(iv) Inform the enrollee of his or her right to appeal the disenrollment decision as set forth in WAC 182-25-100 and 182-25-105.

(b) The notice of disenrollment will be sent to both the employer or sponsor and to all members of an employer group, home care agency group or financial sponsor group that is disenrolled under these provisions. Enrollees affected by the disenrollment of a group account will be offered coverage under individual accounts. Coverage under individual accounts will not begin unless the premium for individual coverage is paid by the due date for the coverage month. A one-month break in coverage may occur for enrollees who choose to transfer to individual accounts.

(5) Enrollees covered under BHP Plus or receiving maternity benefits through medical assistance will not be disenrolled from those programs when other family members lose BHP coverage, as long as they remain eligible for those programs.

(6) Under the provisions of this subsection, BHP will suspend or disenroll enrollees and groups who do not pay their premiums when due, including amounts owed for subsidy overpayment, if any. Partial payment or payment by check which cannot be processed or is returned due to non-sufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, BHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a final due date and a notice that BHP coverage will lapse unless payment is received by the final due date.

(b) Except as provided in (c) of this subsection, coverage will be suspended for one month if an enrollee's premium payment is not received by the final due date, as shown on the delinquency notice. BHP will send written notice of suspension to the subscriber, which will include:

(i) The effective date of the suspension;

(ii) The due date by which payment must be received to restore coverage after the one-month suspension;

(iii) Notification that the subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and

(iv) Instructions for filing an appeal under WAC 182-25-105.

(c) Enrollees whose premium payment has not been received by the delinquency due date, and who have been suspended twice within the previous twelve months will be

disenrolled for nonpayment as of the effective date of the third suspension.

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment, which will include:

- (i) The effective date of the disenrollment; and
- (ii) Instructions for filing an appeal under WAC 182-25-105.

(7)(a) Unless otherwise specified in this chapter, enrollees who voluntarily disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to this provision will be made for:

(i) Enrollees who left BHP for other health insurance, who are able to provide proof of continuous coverage from the date of disenrollment, and who apply to reenroll in BHP within thirty days of losing the other coverage;

(ii) Enrollees who left BHP because they lost eligibility and who subsequently become eligible to reenroll; and

(iii) Persons enrolling in subsidized BHP, who had enrolled and subsequently disenrolled from nonsubsidized BHP under subsection (1) or (2)(b) of this section while waiting on a reservation list for subsidized coverage.

(iv) Enrollees who were disenrolled by BHP because no MHCS was contracted to serve the program in which they were enrolled in the geographic area where they live; these enrollees may reenroll, provided all enrollment requirements are met, if a MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another BHP program.

(v) Enrollees who were disenrolled for failing to provide requested documentation of income or eligibility, who had attempted to comply with the request but were unable to meet the due date, and who provide all required documentation within six months of disenrollment and are eligible to reenroll.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll prior to the end of the required twelve-month wait. If an enrollee satisfies the required twelve-month wait after applying for subsidized coverage and while waiting to be offered coverage, enrollment will not be completed until funding is available to enroll him or her.

[Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-090, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050, 03-24-040 (Order 03-05), § 182-25-090, filed 11/26/03, effective 12/27/03. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5), 02-19-054 (Order 01-07), § 182-25-090, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-090, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090, 99-12-033 (Order 99-01), § 182-25-090, filed 5/26/99, effective 6/26/99. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-090, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-090, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-090, filed 7/9/96, effective 8/9/96.]

WAC 182-25-100 Where to find instructions for filing an appeal. (1) WAC 182-25-105 and 182-25-110 cover appeals submitted by or on behalf of **basic health plan** enrollees or applicants. To appeal a decision regarding a child enrolled in **BHP plus** or a woman receiving **maternity**

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benefits through medical assistance, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapters 388-08 and 388-526 WAC.

(2) WAC 182-25-105 covers appeals of decisions made by the health care authority, such as decisions regarding basic health plan eligibility, premium, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS). Decisions which affect an entire group (for example, the disenrollment of an employer group) should be appealed for the entire group by the employer, home care agency, or financial sponsor, using these same rules.

(3) WAC 182-25-110 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation. The term MHCS, which is defined in WAC 182-25-010(22), refers to the health plan or carrier that provides BHP coverage.

[Statutory Authority: RCW 70.47.050, 99-07-078, § 182-25-100, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-100, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-100, filed 7/9/96, effective 8/9/96.]

WAC 182-25-105 How to appeal health care authority (HCA) decisions. (1) Health care authority decisions regarding the following may be appealed under this section:

- (a) Eligibility;
 - (b) Premiums;
 - (c) Premium adjustments or penalties;
 - (d) Enrollment;
 - (e) Suspension;
 - (f) Disenrollment; or
 - (g) Selection of managed health care system (MHCS).
- (2) To appeal a health care authority decision, enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal must be signed by the appealing party and received by the HCA within thirty calendar days of the date of the decision. The letter of appeal must include:
- (a) The name, mailing address, and BHP account number of the subscriber or applicant;
 - (b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;
 - (c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;
 - (d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(3) When an appeal is received, the HCA will send a notice to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected BHP account, the notice will also be sent to the subscriber.

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals

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committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(5) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

(a) The appeal is received within ten business days of the effective date of the loss of coverage; and

(b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(6) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected BHP account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(7) **Review of initial HCA decision:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(a) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

(i) Be received within thirty days of the date of the initial HCA decision.

(ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

(iii) Provide any additional information or documentation that the appealing party would like considered in the review.

(b) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(c) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(d) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(a) The appeal was submitted according to the requirements of this section; and

(b) The enrollee:

(i) Remains otherwise eligible;

(ii) Continues to make all premium payments when due; and

(iii) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

(9) Enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

[Statutory Authority: RCW 70.47.050, 01-23-095 (Order 00-01), § 182-25-105, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-105, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-105, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

WAC 182-25-110 How to appeal a managed health care system (MHCS) decision. (1) Enrollees who are appealing a MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapter 48.43 RCW and chapter 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

[Statutory Authority: RCW 70.47.050, 01-23-095 (Order 00-01), § 182-25-110, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-110, filed 3/18/99, effective 4/18/99; 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]

WAC 182-25-120 Basic health plan coverage for health coverage tax credit eligible enrollees. (1) "Health coverage tax credit eligible enrollee" or "HCTC enrollee" means an individual or qualified dependent determined by the federal Department of the Treasury to be eligible for a tax credit, as defined under RCW 70.47.020 (3) and (4). In the event that the federal health coverage tax credit program is no longer available, HCTC enrollment in BHP will end.

(2) Eligibility for HCTC enrollment, as subscriber or dependent, is determined by the federal Health Coverage Tax Credit program. HCTC enrollees must provide proof of eligibility for HCTC enrollment, but are not required to also meet the eligibility criteria in WAC 182-25-030.

(3) Unless the enrollee has applied for, is eligible, and has enrolled as a subsidized enrollee, the monthly premium due from or on behalf of an HCTC enrollee will be the full cost charged by the MHCS for coverage, plus the administrative cost of providing BHP coverage and the premium tax under RCW 48.14.0201.

(4) HCTC enrollees may pay the full premium for coverage to BHP or, if they are claiming the HCTC advance tax credit, may pay their portion of the premium to the federal HCTC program of the Internal Revenue Service (IRS) by the date required by the IRS.

(5) With the exception of subsections (3) and (7) of this section, subsidized enrollees who are HCTC eligible will be subject to the rules for subsidized enrollees.

(6) Notice of disenrollment will be sent to the HCTC enrollees for whom the premium has not been paid. This notice will be sent prior to the month of coverage, but will not be subject to the notification requirements in WAC 182-25-090(6). If payment is received no later than the first day of the month of coverage, the enrollee's coverage for that month will be reinstated.

(7) The nine-month waiting period for treatment of pre-existing conditions will be waived for HCTC enrollees who have had three months or more of creditable coverage, as defined under Public Law 104-191, without a break in coverage of more than sixty-two consecutive days at the time of application. Subsidized enrollees who are HCTC eligible, who provide proof of that eligibility to their MHCS, will be treated as HCTC enrollees for purposes of determining whether the preexisting condition waiting period can be waived.

(8) HCTC enrollees who disenroll may return to HCTC enrollment without being subject to the provisions of WAC 182-25-090(7).

(9) Because eligibility for the HCTC program is determined by the federal HCTC program at the Internal Revenue Service, BHP will not review appeals of eligibility for the HCTC program. Instructions on appealing an HCTC eligibility determination are available through the HCTC customer contact center.

[Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-120, filed 11/5/04, effective 1/1/05.]

Chapter 182-50 WAC

PRESCRIPTION DRUG PROGRAMS

WAC

182-50-001	Authority and purpose.
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182-50-200	Endorsing practitioner therapeutic interchange program; effect of practitioner's endorsing status; dispense as written instructions.

WAC 182-50-001 Authority and purpose. RCW 41.05.021 (1)(a)(iii) and 70.14.050 authorize the administrator to establish an independent Washington state pharmacy and therapeutics committee within the health care authority

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to evaluate available evidence of the relative safety, efficacy and the effectiveness of prescription drugs within a class of prescription drugs, in the development of an evidence-based prescription drug program for participating state purchased health care programs. This section requires the administrator to adopt rules governing practitioner endorsement and use of any preferred drug list developed as part of the prescription drug program.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-001, filed 2/23/04, effective 3/25/04.]

WAC 182-50-005 Definitions. When used in this chapter:

(1) "Appointing authority" shall mean the following persons acting jointly: The administrator of the health care authority, the secretary of the department of social and health services, and the director of the department of labor and industries.

(2) "Committee" means the independent Washington state pharmacy and therapeutics committee created by RCW 41.05.021 (1)(a)(iii) and 70.14.050. At the election of the department of social and health services, the committee may serve as the drug use review board provided for in WAC 388-530-1850.

(3) "Drug" means the term as it is defined in RCW 69.41.010 (9) and (12).

(4) "Endorsing practitioner" means a practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any nonpreferred drug in a given therapeutic class.

(5) "Practitioner" means a health care provider, except a veterinarian, as defined at RCW 18.64.011(9).

(6) "Preferred drug" means a drug selected by the appointing authority for inclusion in the preferred drug list used by applicable state agencies for state purchased health care programs.

(7) "Preferred drug list" or "PDL" means the list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased health care programs.

(8) "Prescription" has the meaning set forth in RCW 18.64.011(8).

(9) "Refill" means the continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug.

(10) "State purchased health care" has the meaning set forth in RCW 41.05.011(2).

(11) "Therapeutic alternatives" are drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses.

(12) "Therapeutic interchange" means to dispense, with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-005, filed 2/23/04, effective 3/25/04.]

WAC 182-50-010 Purpose of the pharmacy and therapeutics committee. The purpose of the committee is to evaluate the available evidence of the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and make recommendations to the appointing authority for its deliberation in the development of the preferred drug list established in RCW 70.14.050.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-010, filed 2/23/04, effective 3/25/04.]

WAC 182-50-015 Open Public Meetings Act and Administrative Procedure Act; exception as technical review committee. (1) Meetings of the pharmacy and therapeutics committee shall in all respects comply with the provisions of the Open Public Meetings Act, chapter 42.30 RCW, and shall be subject to the provisions of the Administrative Procedure Act, chapter 34.05 RCW, as applicable.

(2) The pharmacy and therapeutics committee shall constitute a technical review committee created to facilitate the development, acquisition, or implementation of a preferred drug list, for the purposes of state purchased health care under RCW 41.05.026, and as such may hold an executive session in accordance with chapter 42.30 RCW during any regular or special meeting to discuss information submitted in accordance with RCW 41.05.026 (1) through (5).

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-015, filed 2/23/04, effective 3/25/04.]

WAC 182-50-025 Membership and qualifications of pharmacy and therapeutics committee. (1) The committee shall consist of no fewer than ten members appointed by the appointing authority.

(2) The appointing authority has the sole right to appoint committee members and may terminate appointment of any member at any time during the term.

(3) The appointing authority will make appointments to the committee from a pool of interested applicants. Interested persons will be provided an opportunity to submit applications to the appointing authority.

(4) Members shall enter into an agreement with the health care authority at the time of their appointment to the committee and shall act in accordance with all of its terms and conditions. Failure to do so may result in termination of the appointment.

(5) The membership composition at all times shall be consistent with applicable federal requirements under the Federal Social Security Act, Title 19 § 1927 and the requirements of the department of social and health services medical assistance administration for its drug utilization review board. Therefore, pharmacists and physicians each shall represent at least thirty-one percent, but no more than fifty-one percent of committee membership respectively.

(6) Members must be actively practicing in their clinical area of expertise throughout the entire term of their appointments.

(7) Members must have knowledge and expertise in one or more of the following:

(a) Clinically appropriate prescribing of covered outpatient drugs;

(b) Clinically appropriate dispensing and monitoring of covered outpatient drugs;

- (c) Drug use review;
- (d) Medical quality assurance;
- (e) Disease state management; or
- (f) Evidence-based medicine.

(8) Members of the committee shall not be employed by a pharmaceutical manufacturer, a pharmacy benefits management company, or by any state agency administering state purchased health care programs during their term shall not have been so employed and for eighteen months prior to their appointment.

(9) A member shall not have a substantial financial conflict of interest including any interest in any pharmaceutical company, including the holding of stock options or the receipt of honoraria or consultant moneys. The appointing authority in its sole discretion may disqualify any potential member if it determines that a substantial conflict of interest exists.

(10) As part of the application process, prospective committee members shall complete a conflict of interest disclosure form, provided by the appointing authority, and after appointment, annually by July 1st of each year. Members must keep their disclosure statements current and provide updated information whenever circumstances change.

(11) Committee members must agree to keep all proprietary information confidential.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-025, filed 2/23/04, effective 3/25/04.]

WAC 182-50-030 Period of appointment. (1) Members shall be appointed to a term of three years and shall serve until a successor is duly appointed. A member may be reappointed to one additional three-year term for a total of six years. One year after the end of a six-year term, a person is eligible for appointment to one additional three-year term.

(2) Committee members serve staggered three-year terms. Of the initial appointees, in order to provide for staggered terms, some members may be appointed initially for less than three years. If the initial appointment is for less than twenty-four months, that period of time shall not be counted toward the limitation of years of appointment described in subsection (1) of this section.

(3) Vacancies on the committee will be filled for the balance of the unexpired term from nominee lists for the appropriate committee category as provided under WAC 182-50-025.

(4) Members of the committee will be compensated for participation in the work of the committee in accordance with a personal services contract executed after appointment and prior to commencement of activities related to the work of the committee.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-030, filed 2/23/04, effective 3/25/04.]

WAC 182-50-035 Duties. Committee members shall:

(1) Select a chair and a vice-chair from among the committee membership.

(2) Meet at least quarterly and may meet at other times at the discretion of the chair.

(3) Adopt a plan of operation that sets forth the policies and procedures established by the committee to develop an

evidence-based prescription drug program as authorized by state law for approval by the appointing authority.

(4) Operate according to the plan of operation as approved by the appointing authority.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-035, filed 2/23/04, effective 3/25/04.]

WAC 182-50-200 Endorsing practitioner therapeutic interchange program; effect of practitioner's endorsing status; dispense as written instructions. (1) When filling prescriptions for participating state purchased health care programs, pharmacists shall dispense a preferred drug in place of a drug not included in the preferred drug list in a given therapeutic class whenever pharmacists receive a prescription from an endorsing practitioner except:

(a) If the endorsing practitioner determines the nonpreferred drug is medically necessary by indicating "dispense as written" on the prescription; or

(b) If the prescription is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug.

(2) When a therapeutic interchange is made, the pharmacist shall notify the endorsing practitioner of the specific drug and dose dispensed.

(3) When a nonendorsing practitioner issues a prescription for a drug not included in the preferred drug list, the pharmacist shall dispense the prescribed drug in accordance with the requirements of RCW 69.41.100 through 69.41.180.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-200, filed 2/23/04, effective 3/25/04.]

Chapter 182-55 WAC

HEALTH TECHNOLOGY ASSESSMENT PROGRAM

WAC

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WAC 182-55-005 Authority and purpose. Under RCW 70.14.080 through 70.14.140, the administrator of the Washington state health care authority is required to establish and support, and is authorized to adopt rules to govern, a health technology assessment program that uses evidence to make coverage determinations for participating state agencies that purchased health care. The health technology assessment program:

- (1) Selects health technologies for assessment;
- (2) Contracts with an evidence-based technology assessment center to produce health technology assessments;
- (3) Establishes an independent health technology committee; and
- (4) Maintains a centralized, internet based communication tool.

(2007 Ed.)

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-005, filed 11/13/06, effective 12/14/06.]

WAC 182-55-010 Definitions. When used in this chapter:

(1) "Administrator" means the administrator of the Washington state health care authority under chapter 41.05 RCW, as set forth in RCW 70.14.080, as amended.

(2) "Advisory group" means a group established under RCW 70.14.110 (2)(c).

(3) "Committee" means the health technology clinical committee established under RCW 70.14.090.

(4) "Coverage determination" means a determination of the circumstances, if any, under which a health technology will be included as a covered benefit in a state purchased health care program, as set forth in RCW 70.14.080, as amended.

(5) "Health technology" means medical and surgical devices and procedures, medical equipment, and diagnostic tests. Health technologies do not include prescription drugs governed by RCW 70.14.050.

(6) "Participating agency" means the department of social and health services, the state health care authority, and the department of labor and industries, as set forth in RCW 70.14.080, as amended.

(7) "Reimbursement determination" means a determination to provide or deny reimbursement for a health technology included as a covered benefit in a specific circumstance for an individual patient who is eligible to receive health care services from the state purchased health care program making the determination, as set forth in RCW 70.14.080, as amended.

(8) "Health technology assessment" means a report produced by a contracted evidence-based technology assessment center as provided for in RCW 70.14.100(4) that is based on a systematic review of evidence of a technology's safety, efficacy, and cost-effectiveness.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-010, filed 11/13/06, effective 12/14/06.]

WAC 182-55-015 Committee purpose. The purpose of the committee is to make coverage determinations for the participating agencies based on: A health technology assessment that reviews the scientific evidence of the relative safety, efficacy, and cost; information from any special advisory groups; and their professional knowledge and expertise.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-015, filed 11/13/06, effective 12/14/06.]

WAC 182-55-020 Committee selection. (1) The administrator, in consultation with the participating state agencies, shall make appointments to vacant committee positions, including the appointment of a chair, from a pool of interested applicants. Interested persons will be provided an opportunity to submit applications to the administrator for consideration.

(2) When appointing committee members, the administrator will consider, in addition to the membership requirements imposed by RCW 70.14.090 and any other relevant information, the following factors: Practitioner specialty or type and use of health technologies, especially in relation to

current committee member specialty or types; practice location and community knowledge; length of practice experience; knowledge of and experience with evidence-based medicine, including formal additional training in fields relevant to evidence-based medicine; medical quality assurance experience; health technology assessment review experience.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-020, filed 11/13/06, effective 12/14/06.]

WAC 182-55-025 Committee member requirements and terms. (1) As a continuing condition of appointment, committee members:

(a) Shall not have a substantial financial conflict of interest, such as an interest in a health technology company, including the holding of stock options, or the receipt of honoraria, or consultant moneys;

(b) Must complete a conflict of interest disclosure form, update the form annually, and keep disclosure statements current;

(c) Must abide by confidentiality requirements and keep all personal medical information and proprietary information confidential; and

(d) Shall not utilize information gained as a result of committee membership outside of committee responsibilities, unless such information is publicly available. The administrator, in his/her sole discretion, may disqualify committee members if he/she determines that the committee member has violated a condition of appointment.

(2) Committee members shall be appointed to a term of three years and shall serve until a successor is appointed. A member may be reappointed for additional three-year terms for a total of nine years. One year after the end of a nine-year term, a person is eligible for appointment to one additional three-year term. Committee members serve staggered three-year terms. Of the initial members, in order to provide for staggered terms, some members may be appointed initially for less than three years. If an initial appointment is for less than twenty-four months, that period of time shall not be counted toward the limitation of years of appointment. Vacancies on the committee will be filled for the balance of the unexpired term.

(3) The appointed committee chair shall select a vice-chair from among the committee membership; ratify committee bylaws approved by the administrator; and operate the committee according to the bylaws and committee member agreements.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-025, filed 11/13/06, effective 12/14/06.]

WAC 182-55-030 Committee coverage determination process. (1) In making a coverage determination, committee members shall review and consider the health technology assessment. The committee may also consider other information it deems relevant, including other information provided by the administrator, reports and/or testimony from an advisory group, and submissions or comments from the public.

(2) The committee shall give the greatest weight to the evidence determined, based on objective factors, to be the most valid and reliable, considering the nature and source of the evidence, the empirical characteristic of the studies or tri-

als upon which the evidence is based, and the consistency of the outcome with comparable studies. The committee may also consider additional evidentiary valuation factors such as recency (date of information); relevance (the applicability of the information to the key questions presented or participating agency programs and clients); and bias (presence of conflict of interest or political considerations).

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-030, filed 11/13/06, effective 12/14/06.]

WAC 182-55-035 Committee coverage determination. Based on the evidence regarding safety, efficacy, and cost-effectiveness of the health technology, the committee shall:

(1) Determine the conditions, if any, under which the health technology will be included as a covered benefit in health care programs of participating agencies by deciding that:

(a) Coverage is allowed without special conditions because the evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective for all indicated conditions; or

(b) Coverage is allowed with special conditions because the evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective in only certain situations; or

(c) Coverage is not allowed because either the evidence is insufficient to conclude that the health technology is safe, efficacious, and cost-effective or the evidence is sufficient to conclude that the health technology is unsafe, ineffectual, or not cost-effective.

(2) Identify whether the determination is consistent with the identified Medicare decisions and expert guidelines.

(3) For decisions that are inconsistent with either the identified Medicare decisions or expert guidelines, specify the reason(s) for the decision and the evidentiary basis.

(4) For covered health technologies, specify criteria for participating agencies to use when deciding whether the health technology is medically necessary or proper and necessary treatment.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-035, filed 11/13/06, effective 12/14/06.]

WAC 182-55-040 Publication of committee determinations. (1) The administrator shall publish final committee determinations by posting on a centralized, internet-based communication tool within ten days.

(2) Upon publication, participating agencies will implement the committee determination according to their statutory, regulatory, or contractual process unless:

(a) The determination conflicts with an applicable federal statute or regulation, or applicable state statute; or

(b) Reimbursement is provided under an agency policy regarding experimental or investigational treatment, services under a clinical investigation approved by an institutional review board, or health technologies that have a humanitarian device exemption from the federal food and drug administration.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-040, filed 11/13/06, effective 12/14/06.]

WAC 182-55-045 Advisory group. (1) The committee chair, upon an affirmative vote of the committee members, may establish ad hoc temporary advisory group(s) if specialized expertise or input from enrollees or clients is needed to review a particular health technology or group of health technologies. The purpose or scope of the advisory group and time period shall be stated. The advisory group shall provide a report and/or testimony to the committee on the key questions identified by the committee as requiring the input of the advisory group.

(2) Advisory group membership: An ad hoc temporary advisory group shall include at least three members. Membership should reflect the diverse perspectives and/or technical expertise that drive the need for the specialized advisory group. The advisory group will generally include at least one enrollee, client, or patient; and two or more experts or specialists within the field relevant to the health technology, preferably with demonstrated experience in the use, evaluation, or research of the health technology. If substantial controversy over the health technology is present, at least one expert that is a proponent or advocate of the health technology and at least one expert that is an opponent or critic of the health technology should be appointed. A majority of each advisory group shall have no substantial financial interest in the health technology under review.

(3) As a continuing condition of appointment, advisory group members:

(a) Must complete an advisory group member agreement, including a conflict of interest disclosure form, and keep disclosure statements current;

(b) Must abide by confidentiality requirements and keep all personal medical information and proprietary information confidential; and

(c) Shall not utilize information gained as a result of advisory group membership outside of advisory group responsibilities, unless such information is publicly available.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-045, filed 11/13/06, effective 12/14/06.]

WAC 182-55-050 Health technology selection. (1) Prior to selection of a health technology for review or rereview, the administrator shall consider nominations from participating agencies and recommendations from the committee. The administrator may also consider petitions from interested parties. The administrator shall make available, including publication to the centralized internet-based communication tool required at RCW 70.14.130, a petition for interested parties to request a health technology be selected for a review or rereview. Interested parties shall complete the petition and submit it to the administrator. The administrator, or designee, will provide copies of the petition to participating agencies and the committee for comment, and provide the completed petition, with any comments, to the administrator for consideration.

(2) Interested parties that have submitted a petition for the review or rereview of a health technology that was not selected by the administrator may submit the petition to the committee for review or rereview.

(3) The committee may consider petitions submitted by interested parties for review or rereview of a health technol-

ogy. The committee shall apply the priority criteria set forth in RCW 70.14.100.

(4) A health technology selected by the committee shall be referred to the administrator for the next available contract for health technology assessment review.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-050, filed 11/13/06, effective 12/14/06.]

WAC 182-55-055 Health technology assessment. (1) Upon notice of the selection of the health technology for review, the administrator shall post an invitation for interested parties to submit information relevant to the health technology for consideration by the evidence-based technology assessment center. Such information shall be required to be submitted to the administrator, or designee, no earlier than thirty days from the date of the notice.

(2) Upon notice of the selection of the health technology for review, the administrator shall request participating agencies to provide information relevant to the health technology, including data on safety, health outcome, and cost. Such information shall be required to be submitted to the administrator, or designee, no earlier than thirty days from the date of the notice.

(3) Upon notice of the selection of the health technology for review, the administrator shall require staff to identify and organize relevant federal Medicare national coverage determinations and expert treatment guidelines, and any referenced information used as the basis for such determinations and/or guidelines.

(4) The administrator shall provide all information relevant to the selected health technology to the evidence-based technology assessment center; and shall post such information, along with the key questions for review, on a centralized, internet based communication tool.

(5) Upon completion of the health technology assessment by the evidence-based technology assessment center, the administrator shall provide the committee with:

(a) Final copy of the health technology assessment;

(b) Information as to whether the federal Medicare program has made a national coverage determination;

(c) A copy of identified national coverage decisions and accompanying information describing the basis for the decision;

(d) Information as to whether expert treatment guidelines exist, including those from specialty physician organizations and patient advocacy organizations; and

(e) A copy of identified guidelines and accompanying information describing the basis for the guidelines.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-055, filed 11/13/06, effective 12/14/06.]